Ontario

Ministry of Health and Long-Term Care

Operational Review of the Queensway-Carleton Hospital

Final Report

February 26, 2001

first consulting group FCG

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Introduction

The Ministry of Health and Long-Term Care (MOHLTC) and the Queensway-Carleton Hospital (QCH) undertook to conduct an operational review of the hospital with two overall objectives:

- Explain the reason for the operating and working funds deficits.
- Identify what needs to be done to achieve improved and stable financial performance in the face of increasing fiscal and programming pressures.

The specific objectives of the review were to:

- Conduct an organization-wide assessment of the current financial, clinical and operating performance of QCH to identify opportunities for improving short-, medium- and longer-term cost performance.
- Assess the governance, management and decision-making structures in place, including all decision-making processes in place across the organization.
- Review and assess the status and impact of program and service changes as a result of HSRC directives.
- Construct a recovery plan that will support the full implementation of recommendations in order to achieve and sustain improved performance in the long term.

First Consulting Group (FCG) and Geyer Szadkowski Consulting were engaged to conduct this review. This report documents the findings of the review, which was directed at understanding the hospital's deficit and looking for opportunities for improved performance. It has included detailed analysis of clinical, financial and demographic data, interviews with board, medical staff and hospital staff, managers and executives, and discussions with other stakeholders such as the MOHLTC, CCAC, members of the West Ottawa Valley Network, the Ottawa Hospital and others.

We appreciate the cooperation we have had from all parties as we have carried out this review.

Queensway-Carleton Hospital Profile

The Queensway-Carleton Hospital is a 201-bed patient and family focused hospital that provides primary and secondary services to the residents of Ottawa-Carleton• primarily the burgeoning population of the west end communities in West Ottawa, Nepean, Kanata, Goulbourn, Rideau and West Carleton• and is a referral centre for several rural hospitals and communities in the upper Ottawa Valley. The Health Services Restructuring Commission (HSRC) directions for QCH called for the expansion of the emergency room, birthing suites, mental health and ambulatory care. Program transfers as a result of the directives included the obstetrics and gynecology program from the Salvation Army Grace Hospital and the transfer of QCH's chronic care services to the Sisters of Charity of Ottawa Health Services. The addition of the Maternal/Newborn/Gynecology program transferred from the Grace and the introduction of a CT Scan have already been completed. Additional patient capacity for Emergency, ICU, the Operating Suite, Mental Health, Ambulatory Care and Rehabilitation Services will result in an additional 50 beds to the organization by 2003.

ORGANIZATION PROFILE

QCH is known for its consultative approach to planning and delivery of services and has a 24-year history of partnerships and linkages across the Region and in the Ottawa Valley with other hospitals, community agencies, and the business and donor communities.

QCH has five cornerstone programs:

- Emergency Services – specially trained physicians and nurses providing a 24-hour service for children and adults.
- Medical and Surgical Services – cardiology, neurology, respirology, internal medicine, endocrinology, haematology, general surgery, gynecology, orthopaedics, urology, plastic surgery, ear-nose-throat surgery, palliative care, intensive care/coronary care unit and a variety of clinics.
- Mental Health Services – an inpatient unit, psychiatry and psychology services, day and evening treatment programs, outreach and clinics.
- Geriatric Services – specialized programs with geriatrician and clinical nurse specialist; day hospital, geriatric assessment and outreach program.
- Maternal and Newborn Services – A family-centred Childbirth Centre.

A broad range of diagnostic, therapeutic, supportive and volunteer services supports these programs. Expansion and enhancements now in the design stage include an expanded Emergency, ICU, Operating and Procedure Rooms, Mental Health beds, Ambulatory Clinics, and new Rehabilitation beds.

BENCHMARK HOSPITALS

Part of the operational review process was to benchmark QCH against peer hospitals. The benchmarking results are presented throughout this report. Nine hospitals were selected for benchmarking. The criteria used for the selection of these hospitals included:

- Similarity to QCH in terms of:
  - Facility size as measured by total equivalent weighted cases
  - Program mix as measured by:
    - Percentage tertiary weighted cases
    - Percentage non-acute inpatient weighted cases
  - Referral population in terms of household income
- Efficiency as measured by the percentage under/over expected cost per equivalent weighted case.
- Proximity to tertiary care (assessed qualitatively).

Based on these criteria, the hospitals selected for benchmarking included:

- Montfort Hospital, Ottawa
- Markham Stouffville Hospital
- Guelph General Hospital
- St. Mary's Hospital, Kitchener
- Joseph Brant Memorial Hospital, Burlington
- St. Catherine's General Hospital
- Scarborough Salvation Army Grace General Hospital
- Orillia Soldiers' Memorial Hospital
- Greater Niagara General Hospital, Niagara Falls

QCH expressed some concern about not having hospitals with a similar high volume of emergency visits. We did not use this as a criterion because most hospitals with 55,000 to 60,000 emergency visits also have a bed complement to support that volume. As the data comparisons will show, few hospitals could likely be totally effective as benchmarks for this organization because of the uniqueness of their situation. We have attempted to note where comparisons are too difficult from which to draw definitive conclusions.

DESCRIPTION OF MARKET

QCH's catchment area has a population base of approximately 750,000 people. The vast majority of patients served come from the area of Ottawa-Carleton, which includes Ottawa, Nepean, Kanata, Goulbourn, West Carleton, Rideau, Gloucester, Osgoode, Cumberland, Vanier, and Rockcliffe Park. The majority of cases come from Ottawa, Nepean and Kanata, which account for almost 75% of the QCH's activity collectively. QCH's market share is roughly 30% of all its served communities with a greater than 20% share of Nepean, Kanata, Goulbourn, and West Carleton.

Weighted case volumes have risen almost 12 percent over the period analyzed, driven primarily by the rise in secondary cases in the western Greater Ottawa Area (specifically Ottawa, Nepean and Kanata). During the same period services rendered to outlining counties decreased over all levels of care. Exhibit 1 presents the growth in weighted cases by census subdivision (CSD), census division (CD) and other areas. It also shows what percentage of all cases managed at QCH come from these areas (Market Dependence)

Exhibit 1
QCH Market Share of Cases By Census Division and Per Cent of All QCH Cases by Census Division

	Cases					Market Dependence			
Total Weighted Cases	1995/96	1996/97	1997/98	1998/99	3 Year Change	1995/96	1996/97	1997/98	1998/99
Total CSD	9,403	9,502	9,629	10,646	13.2%	85.6%	87.4%	86.2%	86.5%
Total CD	1,205	965	1,053	1,108	-8.0%	11.0%	8.9%	9.5%	9.0%
Total Other	383	411	474	550	43.6%	3.5%	3.8%	4.2%	4.5%
Total Weighted Cases	10,991	10,878	11,166	12,304	11.9%	100.0%	100.0%	100.0%	100.0%

*Includes Same-Day Surgery Cases; Does not include deaths, sign outs, or transfers

Exhibit 2 presents the distribution of cases by primary, secondary and tertiary level of care.

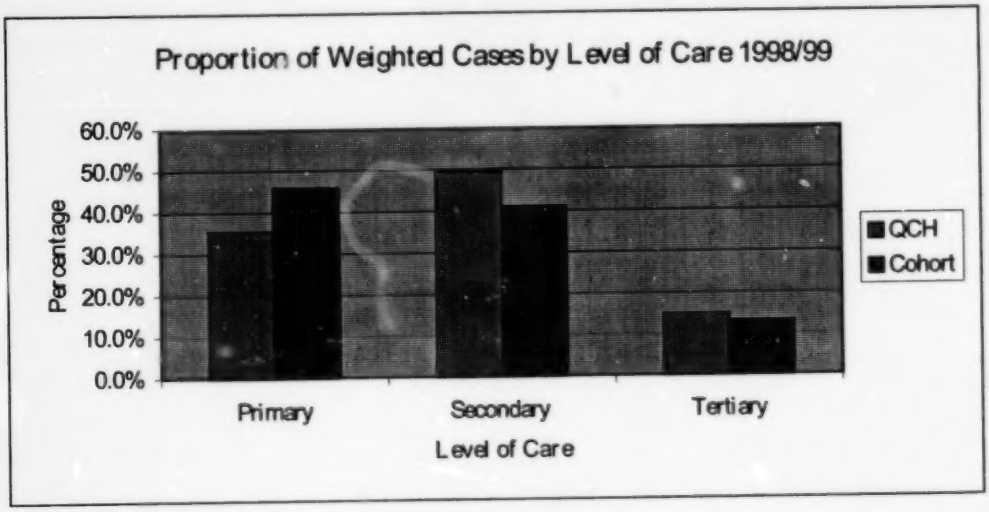
Exhibit 2
Distribution of QCH Cases by Primary, Secondary and Tertiary Level of Care

	Weighted Cases				
Total Weighted Cases	1995/96	1996/97	1997/98	1998/99	3 Year Change
Total Primary	3,356	3,093	3,270	3,697	10.2%
Total Secondary	4,644	4,913	4,986	5,376	15.8%
Total Tertiary	1,501	1,423	1,340	1,534	2.2%
Total Weighted Cases	9,501	9,429	9,596	10,607	11.6%

*Does not include Same-Day Surgery Cases, deaths, sign outs, or transfers

Roughly 50% of all cases are secondary care, with primary and tertiary cases accounting for 35% and 15% of all cases, respectively. This represents a distinct difference from the cohort hospitals, where the case mix by level of care shows how different QCH is from its comparator hospitals of similar size and program mix. Exhibit 3 presents this comparison:

Exhibit 3
Comparison of Case Mix by Level of Care Between QCH and Cohort Hospitals



The most dramatic difference between QCH and the cohorts is the case mix of secondary and tertiary care delivered at QCH (65% of all cases compared to 54% of cohort cases). Tertiary care cases (primarily cases such as hip/knee replacements and some psychiatry), are only slightly higher than the cohorts, while the secondary level cases at QCH are almost 10% higher than the cohorts. The most significant difference in weighted cases can be seen in the volume of orthopedic and general surgery cases performed at QCH. The types of cases included in these two programs will support the significant difference in secondary cases being managed at QCH.

POPULATION GROWTH

As Exhibit 4 demonstrates, growth in the QCH's catchment area is notable. The population of all but one of the adjacent counties surrounding QCH is increasing. The total impact of growth in the area is estimated to be approximately 4.5 percent in five years.

Exhibit 4
Population Growth Projections for the Ottawa-Carleton Region

	2000	2001	2002	2003	2004	2005	5 Year Change
OTTAWA	339,042	340,103	341,012	341,762	342,339	342,724	1.09%
RENFREW COUNTY	100,857	101,652	102,437	103,293	104,081	104,869	3.98%
LEEDS AND GRENVILLE	102,342	103,449	104,376	105,311	106,270	107,177	4.72%
NEPEAN	123,536	124,648	125,743	126,793	127,786	128,764	4.23%
GLOUCESTER	108,336	108,598	109,186	109,756	110,313	110,873	2.34%
LANARK COUNTY	65,703	66,805	67,759	68,752	69,763	70,722	7.64%
KANATA	56,503	58,267	59,564	60,879	62,164	63,457	12.31%
CUMBERLAND	55,829	57,584	59,356	61,135	62,922	64,712	15.91%
VANIER	17,722	17,684	17,672	17,659	17,622	17,588	-0.76%
GOULBOURN	22,253	22,854	23,455	24,061	24,659	25,285	13.63%
OSGOODE	17,750	18,082	18,422	18,750	19,086	19,431	9.47%
WEST CARLETON	17,933	18,140	18,360	18,566	18,776	18,986	5.87%
RIDEAU	13,236	13,353	13,466	13,584	13,696	13,816	4.38%
ROCKCLIFFE PARK	1,786	1,760	1,729	1,709	1,677	1,645	-7.89%
TOTAL	1,044,828	1,054,980	1,064,539	1,074,013	1,083,158	1,092,054	4.52%

Taking this information and applying the regions' expected weighted cases, and QCH's market share in each of those areas, it is estimated that the total impact of population growth on QCH activity with be an additional 12% (or 1,536 weighted cases) by 2005. Isolating QCH's primary referral population of Ottawa, Kanata and Nepean, weighted cases are projected to increase by 11% by 2005. This is outlined in Exhibit 5.

Exhibit 5
Expected Impact of Population Growth on QCH Weighted Cases

	QCH Expected WC's 2000	QCH Expected WC's 2001	QCH Expected WC's 2002	QCH Expected WC's 2003	QCH Expected WC's 2004	QCH Expected WC's 2005	5 Year Change
OTTAWA	4,265	4,309	4,351	4,388	4,421	4,456	4.47%
RENFREW COUNTY	569	579	588	601	611	624	9.66%
LEEDS AND GRENVILLE	151	154	157	161	164	167	10.71%
NEPEAN	4,025	4,123	4,227	4,335	4,440	4,545	12.90%
GLOUCESTER	152	154	158	162	165	169	11.46%
LANARK COUNTY	463	475	485	494	505	515	11.05%
KANATA	1,699	1,774	1,846	1,931	2,016	2,108	24.09%
CUMBERLAND	53	56	59	62	66	69	31.21%
VANIER	14	14	14	14	14	14	2.39%
GOULBOURN	705	731	761	788	821	851	20.70%
OSGOODE	60	62	65	67	69	72	19.31%
WEST CARLETON	429	442	456	470	486	502	16.97%
RIDEAU	179	185	190	195	202	208	16.26%
ROCKCLIFFE PARK	3	3	3	3	3	3	10.42%
TOTAL	12,767	13,060	13,358	13,671	13,984	14,303	12.03%

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TOTAL	12,767	13,060	13,358	13,671	13,984	14,303	12.03%

RESOURCE INTENSITY WEIGHTS

This difference in case mix is further confirmed in the resource intensity weights for QCH, which are significantly higher than the cohorts. Exhibit 6 presents a comparison of the resource intensity weights (RIW) for QCH compared to cohort hospitals.

Exhibit 6
Resource Intensity Weights Comparisons for QCH and Cohort Hospitals

Average RIW	1995/96	1996/97	1997/98	1998/99	3 Year Change
Cohort Acute	1.01	1.05	1.06	1.09	7.3%
Cohort Day Surgery	0.24	0.24	0.24	0.24	0.0%
QCH Acute	1.47	1.62	1.56	1.59	7.5%
QCH Day Surgery	0.23	0.23	0.23	0.23	0.0%

QCH as a % of Cohort	1995/96	1996/97	1997/98	1998/99	3 Year Change
Acute	146%	154%	147%	146%	0.2%
Day Surgery	96%	96%	96%	96%	0.0%

The case severity of QCH is significantly higher than that of its peers and has been for the entire period analyzed. Growth in the acute case severity is consistent with QCH's peers at approximately 7%.

* * * *

Overall, the profile of QCH is different than many hospitals that would typically be considered its peers. The volume of emergency room activity that places unusual demands on inpatients beds and services and the growth in specialty (secondary and tertiary) services at the hospital are the primary differentiators making QCH a unique entity in the Ontario health system. QCH is now more than a community general hospital• it has taken on distinct characteristics of a referral centre.

Financial Performance

This chapter provides a summary of the origin of the deficit at QCH and the factors that are driving costs up. The period under review is from 1996/97 to 2000/01.

CHANGES IN EXPENDITURES BETWEEN 1996/97 AND 2000/01

Revenues vs. Expenditures Between 1996/97 and 2000/01

QCH operated with a balanced budget or a small surplus each year until 1995/96, when the first operating deficit was reported. The deficit has increased each year, and for the year ending March 31, 2000, the reported operating deficit was over $7 million. In the current fiscal year, the deficit is expected to be in the range of $9 million. Exhibit 7 shows a summary of operating statements for the period 1996/97 to 2000/01.

Exhibit 7
Queensway-Carleton Hospital Operating Statements for 1996/97-2000/01 ($000)

	1996/97	1997/98	1998/99	1999/00	Projected 2000/01
	$44,913	$44,768	$48,778	$55,443	$63,236
REVENUES					
Expenses	44,883	46,702	50,399	59,453	70,951
Operating Surplus/(Deficit)	$ 30	$ (1,934)	$ (1,621	$ (4,010)	$ (7,715)
	$ 558	$ 185	$ 409	$ 3,300	$ 1,000
RESTRUCTURING EXPENSE					
Restructuring Reimbursement	-	413	223	151	200
TOTAL Surplus/(Deficit)	$ (528)	$ (1,706)	$ (1,807)	$ (7,159)	$ (8,915)
Working Capital	$ 990	$ (53)	$ (974)	$ (6,923)	$(17-18M)

Source: 1996/97, 1997/98, 1998/99, 1999/2000 from audited financial statements. 2000/01 forecast or projection prepared by QCH as at October 3, 2000.

Revenue has increased by 33% during the period from 1996/97 to 2000/01. The sources of revenue increases are varied, including base adjustments, "one-time" funding, program transfers and restructuring initiatives. The most significant increase was related to the transfer of the maternal/newborn program from the Salvation Army Grace Hospital (the Grace) last year.

Although revenue has increased, operating expenses have grown at a much faster rate. In fact, expenditures have grown 55% over this same five-year period. The deficit has grown each year in the review period, with the most dramatic changes occurring in 1999/00 and in the current fiscal year. A

number issues can be identified that have contributed to the increased gap between revenue and expenditures:

- Increase in activity and acuity.
- The impact of inflation.
- HSRC-directed program transfers that cost more to operate than the additional funds provided (for a variety of reasons).

Each of these factors will be discussed in more detail below.

Growth in Activity and Acuity

Exhibit 8 presents the growth in activity levels since 1996/97. This exhibit excludes the maternal/newborn program transfer because it does not represent a growth in existing activity. Acuity increases have previously been presented in Exhibit 6.

Exhibit 8
Growth in Activity at Queensway-Carleton Hospital*

	1996/97	1997/98	1998/99	1999/00	Per Cent Change
Weighted Cases**	11,602	11,899	13,089	14,399	24%
Day/Night Care	10,800	11,000	11,496	12,459	15%
ER Visits	50,730	50,823	52,870	54,460	7%
Clinic Visits	120,254	126,640	137,664	151,729	26%
D&T Workload Units	8,647,698	8,964,254	9,160,400	9,330,500	8%
Overload Patient Days***	1,313	2,834	2,865	2,473	88%

* Source: Hospital Utilization Department
** Weighted cases have been calculated using CMG99 and day surgery cases are included.
*** Overload patient days refer to admitted patients held in temporary locations waiting for an inpatient bed (primarily the ER observation area and the day surgery area)

This exhibit clearly shows that the growth in activity has been significant, and the most significant growth has occurred in the past two years. The 24% growth in weighted cases far exceeds the growth of the population in the catchment area. The magnitude of this increase has been masked to a degree by changes in workload measurement and reporting tools. In 2000/01, a further 15-17% growth in weighted cases is projected.

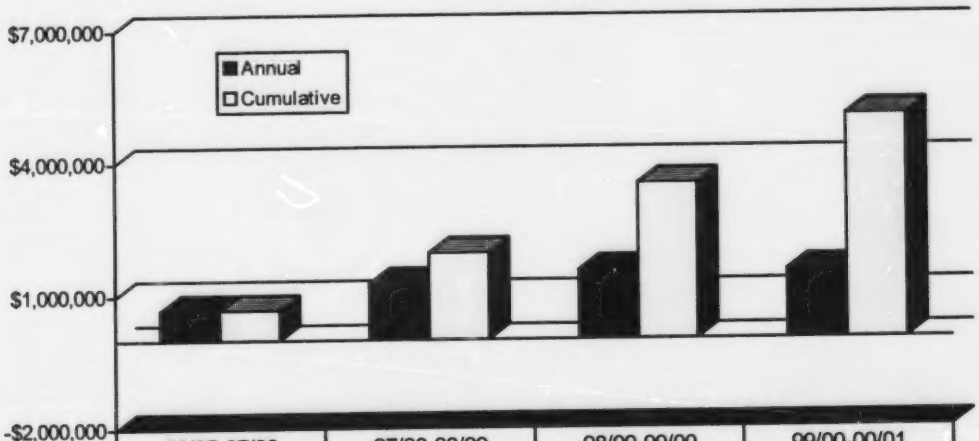
Few facilities in the province have similar service portfolios or such limited access to long-term care or rehabilitation beds. The growth in overall activity levels is also above provincial norms and program transfers have had a major impact on operations. This has contributed to the pressures on inpatient beds. For example, the patient overload days are days spent by admitted patients in stretchers in observation areas, and are over and above the growth that has been accommodated through new beds that have been opened over the last two years.

Between 1996/97 and 1999/00, the cost of this increase in activity exceeds $10 million. (calculated by multiplying the growth in activity by direct costs). This therefore represents a conservative estimate of total incremental costs. The issue of appropriateness of this growth can be challenged. The growth has however occurred and it is a major factor in the growth of total expenditures over this period.

Impact of Inflation

New revenue is not confined to new or expanded programs. The first call on any new funds has to be for sustaining existing operations. The impact of wage and salary increases on operations is known for each of the years under review. Estimates can also be made for the impact of inflation on supplies and other cost categories. Exhibit 9 presents the impact of inflation and shows cost pressures of between $700,000 and $1.5 million in the years under review. The estimates were prepared by QCH and have been reviewed for reasonability using contract settlements and national inflation indices.

Exhibit 9
Growth in the Cost of Inflation at QCH from 1996/97 to 2000/01



	96/97-97/98	97/98-98/99	98/99-99/00	99/00-00/01
Annual	$682,000	$1,279,000	$1,554,000	$1,541,000
Cumulative	$682,000	$1,961,000	$3,515,000	$5,056,000

The full impact of the increases in 2000/01 will only be felt in the 2001/02 fiscal year. In addition, recent contract settlements in the Ottawa area will likely impact negotiations at QCH. Additional labour costs may be incurred or accrued for in the current fiscal year as a result.

The Special Circumstance of the Maternal/Newborn and Gynecology Program Transfer

The transfer of the maternal/newborn and gynecology program from the Salvation Army Grace Hospital (the Grace) to QCH in December 1999 has contributed significantly to the operating deficit.

Initial Transfer Funding Allocation

In August 1997, the HSRC directed QCH to develop an implementation plan for the transfer of the maternal/newborn and gynecology program from the Grace to QCH. Data from the OCDM for 1996/97 reported a direct cost per weighted case of $1,308 at the Grace and $1,405 at QCH. The QCH 1998/99 cost per weighted case of $1,470 was applied to the 3,084 maternal/newborn and gynecology cases at the time of the transfer.

This program has been operating at a deficit since the time of the transfer. The conclusion of this review is that the funding transferred was not sufficient to cover operating costs.

The Ministry has an established process to conduct post program transfer reviews. Such a review will determine the adequacy of the program funding at the time of the transfer, assuming all aspects of the program remained equal.

Changes in the Program Post-Transfer

The program at QCH today is very different than the program that was offered at the Grace prior to the transfer:

- Volumes have increased.
- Service enhancements have been introduced (such as a lactation consultant).
- The average acuity of patients has increased.

These changes, all of which have affected the cost of this program, cannot be addressed by the post program transfer review. They must be addressed through the operating plan process.

A review of the funding for this program is urgently needed. Such a review should address not only the funding at the time of the transfer (as is determined in a post program transfer review), but also should include the operating costs associated with changes in the program since the date of transfer.

Chronic Care

In July 1998, the HSRC directed QCH to develop a plan to transfer the chronic care program from QCH to the Sisters of Charity of Ottawa Health Service (SCOHS). These beds were closed prior to the opening of the maternal/newborn and gynecology program without transferring the program to SCOHS. The planning for the closure of these beds was documented at QCH, and occurred over a period of time, although the majority of the impact of the closure was experienced in 1999.

The funding for this program was never removed from the funding base for QCH. This revenue was used to fund growth and to offset the growing deficit. As a result, unit costs in acute care were increased by the direct and indirect costs now allocated to acute care that had previously been allocated to chronic care. In 1997/98, chronic care represented 4.9% of direct costs. An estimated $2.4 million was reallocated top acute care as a result of this program change. A total of $600,000 in co-payment revenue was also lost.

At an operational level, the impact of closing these beds before alternate facilities were available in the field cannot be underestimated. An inability to transfer patients to other facilities has compounded the ALC problem and impacted all areas of operation. Efforts have been made to reduce the costs associated with the care of these patients, with specific initiatives to create a program for them or otherwise bring the costs more in line with long term care funding. This has met with limited success because of the fluctuation in numbers of ALC patients and challenges associated with creating such programs and the associated resource costs that they require. We understand that HSRC directives noted that these beds should not be closed until replacement beds were in place. In hindsight, even the 15 beds assigned to QCH in the past would have contributed in only small ways to the current pressures on acute care beds.

The Current Fiscal Situation

The operating deficit is not the only challenge that needs to be addressed. QCH is facing a financial crisis.

- Working capital has been depleted.
- Money has been borrowed from capital funds to support operations.
- Capital expenditures (plant and equipment) have been deferred wherever possible for a number of years.

Current operating expenditure levels exceed available operating funding by approximately $700,000 per month. QCH will run out of cash by the end of February if expenditure levels are not reduced or if new sources of revenue are not found. Working capital needs to be restored and the balance sheet needs to be strengthened if QCH is to remain a viable entity.

As noted earlier, QCH has been projecting an operating deficit of greater than $10 million in the current fiscal year. Therefore, the projected working capital deficit position at the end of 2000/01 will be in excess of $17 million before allowing for funding announcements made by the Ministry on October 27th and November 7th, 2000. Exhibit 10 shows the Hospital's working capital position.

Exhibit 10
Queensway-Carleton Hospital – Working Capital and Net Assets Position

	March 31, 1997 ($000)	March 31, 1998 ($000)	March 31, 1999 ($000)	March 31, 2000 ($000)
Current Assets	$ 4,672	$ 5,171	$ 6,548	$ 6,278
Long Term Assets	$ 11,577	$ 15,060	$ 16,707	$ 24,936
Total Assets	$ 16,249	$ 20,231	$ 23,255	$ 31,214
Current Liabilities	$ 3,682	$ 5,224	$ 7,522	$ 13,201
Long Term Liabilities	$ -	$ 7,863	$ 10,396	$ 19,835
Total Liabilities	$ 3,682	$ 13,087	$ 17,918	$ 33,036
Fund Balances	$ 12,567	$ 7,144	$ 5,337	$ (1,823)
Working Capital	$ 990	$ (53)	$ (974)	$ (6,923)

The financial situation would be even more critical if QCH had not taken the decision to use part of the "Superbuild Capital Advance" to fund operating expenses over the past year. Based on a letter of agreement signed by the Board Chair in March 2000, the use of this fund is not appropriate. Not only does it mask critical working capital shortfalls, it also creates liabilities that will likely not be included in Ministry planning processes, and represents a liability that will have to be re-paid by QCH before its use is required for the capital expansion.

The shortage of cash has resulted in the deferral of plant and equipment expenditures wherever possible. Purchases have generally been confined to situations where critical pieces of equipment have broken down or pose patient and/or staff safety risks. Routine renewal and replacement practices have been bypassed over the past few years. This will result in increasing demands for equipment expenditures in the future. These kinds of expenditures can be deferred, but they cannot be eliminated. Planning needs to provide for growth in expenditures in this area over the next few years as equipment is renewed and replaced.

The extent of the problem is masked to a degree by the amounts being spent in new program areas (e.g. maternal/newborn). At a balance sheet level these expenditures create the impression that significant funds are being spent on plant and equipment. In reality, most of the funds are being directed to the new programs while expenditures on existing capital assets are confined to critical situations. The most recent list of equipment requirements illustrates the extent and nature of the problem.

CHANGES IN PERFORMANCE EFFICIENCY BETWEEN 1996/97 AND 2000/01

Overall unit costs have increased at QCH for the period under review. When looking at the change in unit cost as measured by the cost per weighted case, QCH has historically performed with an actual cost per weighted case that was less than the expected cost per weighted case. In 1998/99, the actual cost per weighted case exceeded the expected cost for the first time.

Between 1997/98 and 1998/99, the reported cost per weighted case rose from $2,176 to $2,581. This increase of 18.8% was twice as much as the general increase in Ontario hospitals in that year. It was atypical and misleading for a number of reasons:

- One-time costs associated with restructuring were not separately accounted for, and were included in operating costs and therefore the calculation of cost per weighted case. These costs were temporary and should be managed out of the system, and therefore reflect an artificial jump in unit costs. They include costs such as Y2K and restructuring costs.
- The weighted case methodology has changed from year to year. This was a particular issue in 1998/99.
- The day surgery incentive was removed, thereby increasing unit costs for inpatient activity.
- Transitional costs associated with the chronic care program closure were also not separately reported.
- Nursing enhancement programs raised unit costs in this year for all hospitals across the province.

Each of these points is discussed briefly below.

One-time and Transition Costs

Many Ontario hospitals only identify and report restructuring costs that qualify for reimbursement by the Ministry. With Y2K projects and restructuring initiatives under way across the Province, operating costs (and cost per weighted case) can include significant one-time costs. Such costs should not be repeated and should be managed out of the system. As a result of this practice, however, deficit estimates are likely overstated if these costs are not identified and excluded from future projections.

At QCH, these costs included the maternal/newborn transfer and Y2K initiatives. The program transfer was attempting to accommodate Y2K challenges at the Grace that imposed a deadline of the end of 1999 for the transfer. If this date were not met, significant expenditures would need to have been incurred at the Grace to upgrade systems ($4 million). However, because PCOBs were not fully prepared for the maternal/newborn program transfer in order to expedite the process, some costs were not planned for and the opportunity to negotiate additional restructuring support was lost.

As a result, a significant amount of one-time and transition costs were not reported as restructuring costs in the reports and submissions to the Ministry. These costs were included in base costs at a departmental level and have inflated unit costs. These costs should work their way out of the system in future years and will have to be included as expected savings in the recovery plan. These restructuring and Y2K costs include:

Information systems -	$400,000
Communications -	$100,000
Plant operations -	$100,000
Housekeeping -	$150,000
TOTAL	$750,000

Changes in Case Weight Grouping Methodology

The change in weighted cases across fiscal years has been complicated by the annual change in the CIHI case weight grouping methodology. The multi-year case weight data prepared by the JPPC does not provide any truly comparable data, because the weighted cases are specific to their fiscal year. Individual hospitals are able to prepare multi-year weighted case comparisons by using a common grouper and applying that methodology across fiscal years.

The change in weighted cases from 1997/98 to 1998/99, using 1998/99 as the standardized grouping methodology, is presented in Exhibit 11.

Exhibit 11
Comparison of Reported and Comparable Weighted Case Volume
Changes at QCH from 1997/98 to 1998/99
Using 1998 as the Standardized Grouping Methodology

	1997/98	1998/99	% Change
OCDM Reported Weighted Cases	10,353	10,612	2.5%
Standardized Weighted Cases	9,359	10,323	10.3%

If the true volume increase were reflected, the revised cost per weighted case for 1998/99 would be $2,422 rather than $2,581, a reduction in cost per weighted case of $159. The expected cost per weighted case for this same period showed an anticipated 10% growth. This is significantly over inflation or other cost increases and provides support for a consideration of the weighted case grouping methodology as a factor in reported cost increases.

Day Surgery Incentive

The elimination of the day surgery incentive model in 1998/99 also impacted unit costs. QCH had received a 150 weighted case credit in 1997/98 to compensate for lost inpatient credit. This practice

was discontinued in 1998/99. If this incentive had been included in 1998/99, the impact on the cost per weighted case would have been a reduction of $31 per weighted case in 1998/99.

Nursing Enhancement Costs

The Nursing Enhancement Fund of $3 million in 1998/99 was a combination of a net increase of $1.4 million in acute care nursing and approximately $1 million that was allocated to outpatient areas. (the net difference is the result of annualization of costs).

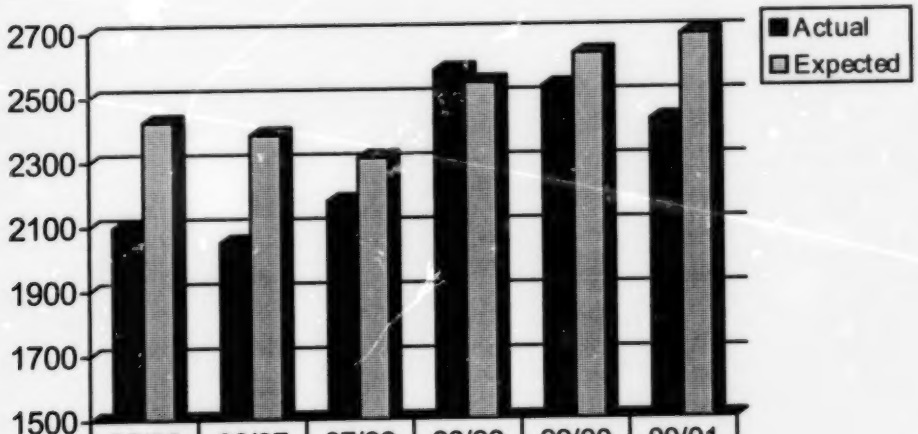
These enhancements have contributed $117 to the average cost per weighted case.

IMPROVEMENTS IN EFFICIENCY IN THE FUTURE

As noted in the above sections, explanations for the increase in expenditures and the perceived decrease in efficiency between 1996/97 and 2000/01 are clear. Based on our review, we fully anticipate that these costs can be managed out of the system and the Hospital will soon return to being the efficient performer that it has been in the past.

Exhibit 12 presents a projected shift in the actual vs. expected cost per weighted case between 1995/96 and the current year 2000/01.

Exhibit 12
Trends in Cost Per Weighted Case at QCH Between 1995/96 and 2000/01



	95/96	96/97	97/98	98/99	99/00	00/01
Actual	2097	2050	2176	2581	2530	2425
Expected	2424	2383	2311	2542	2631	2690

This exhibit clearly shows that the Hospital was operating quite efficiently until 1998/99 in terms of its unit costs. The trend in a reduction in actual cost per weighted case compared to the expected cost per weighted case is already showing that increased unit costs described above are beginning to disappear. We project that an even more significant reduction in cost per weighted case will be seen in this current fiscal year. Specifically, we anticipate that, if the organization is managed appropriately and efficiently, the actual cost per weighted case will be below the expected cost per weighted case in this fiscal year.

Conclusions

Our assessment of the financial situation at QCH has resulted in four key conclusions:

- The deterioration in financial performance at QCH can largely be explained by the growth in activity in current programs, the introduction of the maternal/newborn/gynecology program and one-time and transition costs and inflation.
- Implementing operating efficiencies cannot reverse the deficit at QCH.
- No evidence exists to suggest that after one-time costs are managed out of the system the organization will not return to an actual cost per weighted case that is below the expected cost per weighted case.
- Concerns exist that the transfer of the maternal/newborn/gynecology program was not well managed, which is one of the reasons costs got out of control.
- Working capital needs to be restored ad the balance sheet needs to be strengthened if QCH is to remain a viable entity.
- The Ministry should undertake a post-program transfer review of the maternal/newborn and gynecology program as soon as possible to assess the funding adjustments that are required for this program so that this can be built into the recovery program. This review should focus on five key areas:
    - The initial funding allocation at the time of the program transfer (i.e. the post-program transfer review).
    - Growth.
    - Service enhancements
    - Change in acuity.
    - Economy of scale issues.

Governance and Management

Fundamental to any organization's sound fiscal performance is the effectiveness and consistency of the management practices of the Board, senior management team and medical staff.

BOARD GOVERNANCE

The Governance Process and Fiscal Control

Excellence in governance is achieved when a board fully understands and executes its purpose. In health care organizations, board governance is the process of exercising corporate leadership and being accountable for:

- Vision• setting a future direction for the organization based on mandate
- Mission• confirming the organization's purpose and mandate and providing appropriate access and care for designated populations
- Values• establishing guidelines for acceptable behaviour
- Controls (fiscal, clinical, management)• adjusting activity to meet accountabilities so that service delivery is accomplished within resources provided, Ministry-allocated funds are used responsibly, and investments are managed appropriately.
- Expectations management• managing the need for fiscal and clinical control while recognizing the needs and expectations of the community it serves, its medical staff, its employees and the government.

Managing the relationships between and among these accountabilities is a balancing act. As with most health care organizations today, the achievement of the organization's mission and vision is a continuous process of managing the need for controls against pressures to do more. This has been a balance that has been difficult for the QCH Board. In fairness, it has been more difficult for this Board than for most hospital boards.

In an effort to address the growing deficit, the Board requested this operational review. The Board and senior management had every expectation that this review would confirm that additional funding was needed at QCH. Because of significant growth pressures, the Board knowingly approved an operating deficit for the current fiscal year that will reach almost 17% of revenue. The Board, medical staff and senior management were confident that the results of this review process would acknowledge that:

- The growth in the west end of Ottawa has been unprecedented.
- The Hospital has responded appropriately to this growth.
- The Ministry has supported the Hospital's actions.

The conclusions of the operational review are described throughout this report. Our findings will indicate that the current fiscal situation is not related to inefficiencies and waste. Our findings also indicate that the Board believed that the Ministry endorsed what they were doing. However, the Board should never have considered the operational review as any kind of endorsement to proceed with continued growth in the current fiscal year.

The governance process requires that the Board seek the balance between needs and resources. After almost three years of communications about deficit problems that had gone unanswered, the Board should have:

- Approached all discussions with the Ministry with the expectation that formal commitments and approvals would be received before actions were taken that would significantly increase hospital costs.
- Pressed the management team to develop more comprehensive and compelling plans that supported the Hospital's challenges and created a solid position for the Hospital in order to seek more formal support from the Ministry.
- Requested a realistic and affordable medical human resources plan that could be used to guide decisions about new medical staff.

This re-balancing of meeting needs within resources available is going to be central to the organization's ability to recover its financial control.

The Reasons for a Breakdown in Process

The reasons why the governance process has not worked as effectively as it should at QCH are complex. The most notable reasons that have led to the current fiscal and program crisis in the organization and that should have been addressed before now include:

- The Board's relationship with the Ministry.
- HSRC directives that have affected QCH.
- Unmanaged growth in activity.

Each of these reasons is briefly described below.

The 'Good Faith' Relationship Between the QCH Board and the Ministry of Health

The Board has acted with conscientious attention to the Hospital while deficits have accumulated. It has been fully aware of the situation. Communications about deficits have been relayed to the Ministry on a number of occasions in the past two or three years. The Ministry has mostly reassured the organization that they should not reduce service, and that funding issues would be sorted out.

For example:

- QCH opened 24 beds two years ago to deal with access pressures. The Ministry supported and encouraged this action. The Hospital continues to operate these beds without additional base funding for the increased workload. However, support for an additional 20 acute beds was given to QCH in mid-December, which will offset some of the costs of these beds.

- Concerns about emergency volumes, patient overload situations and cash crises have been the subject of active communications with the Ministry for over two years. No specific communications were received from the Ministry either for the Hospital to reduce service or close beds and refuse growing workload demands or to proceed with expansion of services in response to demand.

- QCH proceeded with plans to accept the transfer of the maternal/newborn and gynecology program from the Grace even though they recognized, albeit within weeks of the transfer, that they would not have sufficient funds to run the program. The Ministry reported that it believed the funding was adequate, and encouraged QCH to accept the program from the Grace. In this operational review, we have concluded that the funding did not cover direct costs.

The Board did request plans for service reduction in the event that this was required. Because of assurances from the Ministry, these were not put into effect.

The Board's decision to allow deficits to accumulate based on assurances from Ministry officials may be understandable. However, the current situation should never have been allowed to get to its current state.

The Board must take primary responsibility for this. It has a clear mandate to live within the resources provided to it, and this has not happened. For the Board, this is a relatively new experience, because of the many years when revenue and expenditures were not a problem. The deterioration, however, has been rapid.

At the same time, the Ministry has not provided the kind of support and counsel that an organization like QCH should expect. While the Board informed the Ministry that financial pressures were increasing, and the Ministry supported the actions of the Hospital, base funding was not adjusted to recognize these changes. The Board has clearly been acting in good faith, and should have had reason to assume that the information that it received from the Ministry was information it could count on for decisions made about hospital operations.

Moving forward, the Board will have to work to establish more realistic communications with the Ministry so that difficult decisions that have significant implications are made in a timely fashion. Further, the Board should be prepared to take action on issues affecting the organization's fiscal health if formal direction from the Ministry is not forthcoming in a reasonable period of time. The Ministry must also endeavour to provide clearer communications to the organization so that it does not make decisions on the belief that support for those decisions exists within the Ministry when it does not.

The Directions of the Health Services Restructuring Commission

The implications of the HSRC directions for Ottawa, and specifically for the Network 7a hospitals, may not fully address the pressures that now exist in Ottawa. Those implications are significant. For example:

- The number of complex continuing care, long term care, rehabilitation, sub-acute and mental health beds was determined by the HSRC based on the application of a population-based benchmarking formula across the province. Chronic care beds were removed from Ottawa, including the closure of beds at QCH and Sisters of Charity, because Ottawa had a disproportionate number of beds compared to other Ontario communities. Three years later, The Ottawa Hospital and QCH are suffering from an overload of ALC patients for whom no long-term care beds are available and will not be available for at least a year or more. These ALC patients have contributed to the access to care issues in Ottawa. QCH closed its chronic care beds before appropriate replacement beds were available in Ottawa (as the HSRC had directed), thereby creating some of the ALC pressures currently being felt.

- The Board and the senior management of QCH, along with the Joint Executive Committee of WOVN, have identified the need for additional capacity at QCH in order to meet new directions. The Ministry has, in this case, approved only the expansion that is supported by HSRC directions. It is clear that this expansion will not address the full capacity requirements of QCH for its own catchment area and for the Network 7a requirements. Until these needs are resolved, the pressures on QCH will continue. A revised plan that includes new directions for the WOVN is due to the Ministry by March 31, 2001.

We are very concerned that current discussions about the development of stronger referral ties with surrounding hospitals, as well as expectations of transferring some of The Ottawa Hospital's primary and secondary caseload to QCH, is not implementable with either current or planned future capacity.

The Unmanaged Growth in Activity at QCH

The growth in activity at QCH that we described in the previous chapter has been a growth in response to demand for services that appears to have gone relatively unchecked. Although much of the demand has come through the Emergency Department, (currently, an unprecedented 82% of inpatient admissions come through Emergency), the response to the demand has not been matched

with a careful assessment of the impact of added services and a reassessment of services currently provided. For example, as emergency pressures increased, a hard look could have been taken at services that are not mission-critical to an emergency service.

New physicians have also been added without comprehensive impact analyses that have included the specific cost impacts of new candidates being considered. Although an impact analysis is prepared when a physician replacement or a new physician is to be recruited, evaluations of actual experience with new physicians compared to what the impact analyses reflected have not been done. In addition, no serious action has been taken on programs and services that are not required to support a heavy Emergency program.

Although this growth in activity is attributed to population growth and associated increased demand, the number of physicians and specialties has been a significant contributor to the growth. Attention to the balance of capacity needs to be a critical part of the approval process for any new physicians and services being introduced.

Conclusions

Our conclusions for the review of the governance process at QCH are that:

- The Board and regional Ministry officials need to establish new ground rules for a positive and proactive working relationship between the Board and the Ministry.
- Through this process, the Board and the Ministry need to agree on an acceptable level of activity for the hospital that will be the basis on funding in the future.
- Once the outcomes of this review are resolved and as the organization moves forward, the Board needs to accept, by resolution, that it has responsibility for the development and maintenance of a balanced budget.
- An urgent need exists to consider the current approved planning initiatives in the context of current and future service needs, and in the context of an appropriate role for QCH in the Ottawa region.
- An urgent need also exists to undertake a detailed assessment of all planning initiatives, priorities and costs to ensure that they are achievable within the funding provided, the timelines set out, and the resources available to carry the planning initiatives to a successful conclusion.
- Once the role of QCH is confirmed, the resolution of current fiscal problems can be addressed. We do not believe a recovery plan can be developed until the question of role is answered.
- Active, appropriate alternatives are needed to address the needs of the ALC patients currently hindering acute care operations and masking the true challenges in bed capacity at QCH.

- The Board needs to undertake a development process to strengthen its understanding of fiscal management and planning issues and create much higher expectations of the senior management team to keep it informed and to have information necessary to demonstrate sound fiscal accountability in the management of the Hospital.

THE WEST OTTAWA VALLEY NETWORK (WOVN)

Several years ago, a number of hospitals formed the Ottawa Valley Hospitals Alliance. Members included QCH, and the hospitals in Arnprior, Kemptville and Carleton Place. The major purpose of the Alliance was to seek methods of collaboration that would benefit everyone. A number of initiatives were undertaken, including:

- A common human resources benefits program, which saved a total of approximately $100,000 for the organizations.
- A regional laboratory service that is now serving as a template for the Eastern Ontario Regional Laboratory initiative.
- Housekeeping services
- Plant services.
- Linen services.
- Joint home oxygen program.
- Bone density program.

The HSRC built on the concept and the experience of this Alliance when it recommended the northern and rural networks. Initially, a network of eight hospitals in the Ottawa region was recommended by HSRC. It included the Ottawa Hospital as the C (referral) hospital for the network, as well as Almonte, Arnprior, Carleton Place, Kemptville, Hawkesbury, Winchester, Perth and Smiths Falls. It excluded QCH. Very quickly, this group was broken into two networks (7a and 7b). Hawkesbury, Winchester, Perth/Smiths Falls and The Ottawa Hospital became a part of other networks, and QCH was reunited with its Alliance partners as a part of Network 7a. QCH was to be the designated C hospital for this network. Once the networks were established, HSRC asked for plans for how the networks would work to reduce costs. Those reports were submitted in the fall of 1999.

Unfortunately, the planning process for Network 7a broke down at the last minute and Almonte excluded itself from the network plan. We understand that the network was proposed as an entirely voluntary process, so no action has been taken to bring Almonte 'back to the table', even though they officially continue to be part of Network 7a.

The Network plan included initiatives to consolidate corporate services and had a very specific plan for clinical services. A strategic plan for the Network is in the final stages of development.

Although on the surface these plans look comprehensive and proactive, we have a number of concerns about the achievability of these plans.

- Current referral patterns of physicians are contradictory to the planned network referral patterns. The expectation that these established referral patterns will change because of a Network initiative may be more difficult to implement than is currently considered. For example:
    - QCH senior management is considering how they could provide a radiology referral service to Arnprior. The WOVN has such a plan in their current initiatives to integrate services across the network. However, radiologists at The Ottawa Hospital currently provide service to Arnprior.
    - QCH orthopedic surgeons currently travel to Pembroke to provide services to that hospital. Network 7a hospitals such as Kemptville currently receive very good orthopedic referral services from Perth and Smiths Falls.
    - QCH provides little or no clinical support to its Network partners because of capacity issues. Many of these partners look to The Ottawa Hospital for support.

- The current activities surrounding the development of a consolidated administrative and support service model for the WOVN are very aggressive. A document outlining the relationship model has been developed, but a decision about whether the model will be a for-profit or not-for-profit shared service model has not been made. The implementation of an integrated Human Resources role is already proceeding. The timeframe for the corporate service integration initiative is of significant concern, given the major role that QCH will play in this process and the many competing priorities the Hospital has.

- A strategic plan for the Network is almost complete and includes a plan for the integration of clinical services. As noted above, how achievable any integration can be until referral patterns are sorted out is not known.

- Current physical plant changes at QCH are not directed at solving any Network referral challenges. A separate plan is being developed to address these.

A Chief Implementation and Integration Officer has been appointed to develop the corporate and diagnostic service plans for the Network. This person is moving aggressively to fulfill the mandate he has been given. We question how much this work is fully 'owned' by the senior management of QCH and why this process seems to have taken precedence over local planning needs.

Conclusions

The WOVN initiative is a sincere and enthusiastic effort to provide a responsible referral service role for QCH and to support the viability of all other Network hospitals. However, this timing of this work needs to be re-thought. The Board needs to:

- Immediately request from the CEO an assessment of the resources (human and financial) required to continue the WOVN initiatives and evaluate this against the immediate planning needs of the Hospital.
- Consider deferring the integration of financial services until the fiscal health of QCH is either restored or firmly in hand.
- Request a priority meeting with the Ministry to discuss the potential for expanding the capital planning process at QCH to match the expected role to serve primary and secondary cases in Network 7a, including the immediate catchment area and the potential for decanting cases from The Ottawa Hospital. Although this has already been requested and is in process for a deadline of March 2001, the outcomes of this discussion will drive any recovery plan, and must be concluded as son as possible in order for a comprehensive financial recovery plan to be developed.

MANAGEMENT PRACTICES – EXECUTIVE LEADERSHIP

The executive leadership of QCH is still seeking a common ground for day-to-day operations. The leadership is very new, with only two people being with the organization for any extended period (i.e. beyond two years).

The Role of Management and Leadership

Hospitals are among the most difficult and complex organizations to manage effectively and efficiently. What distinguishes organizations that achieve success in financial, operational and clinical indicators is their ability to be nimble, to maintain high-energy motivation for success, and to have dedication and commitment to the organization's vision. If the vision is unclear, or if confidence does not exist that the organization's leadership has a strong vision and commitment, organizations will flounder.

The one factor that is always evident in successful organizations is the skills and behaviour of the executive leadership team. And key to those skills and behaviour is managing the balance between the competing influences that challenge every hospital: the demands of the community, the demands of the medical staff, the expectations of the Board and the fiscal resources available to respond to those competing demands.

The current management team is struggling with this balance. In part, this is likely because:

- The team is new and members are not yet fully functioning as a team. Despite positive comments from the Accreditation Survey Team last year, the QCH leadership team is not well synchronized. A cohesive management style and process is needed.

- The team is replacing a long history of stability in senior management, where the vision and direction of senior management was well known and understood across the organization. The vision and the motivations of the current team are unknown to middle management. The confidence in the senior team has therefore wavered over the past two years.

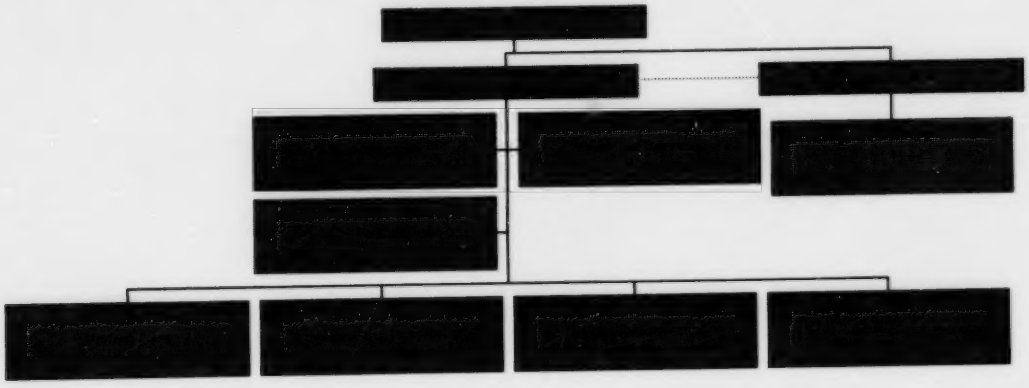
- The team has also come along at a time of unprecedented change in the Hospital. Their ability to manage and lead this change is being continuously challenged.

Recent initiatives have begun to address these issues and to build a more solid foundation for senior management. This will take time, in particular until two vice president positions have been filled and the team is fully functioning.

Senior Management Organization

The current senior management organization of QCH is presented in Exhibit 13.

Exhibit 13
Current Senior Management Structure at QCH



Generally, this organization structure is consistent with the organization structure of hospitals of similar size. Some of the functionality of this structure could be improved with some small modifications:

- Inconsistency exists between the portfolio of the Vice President, Diagnostic, Hospital and Information Services and the role of Chief Information Officer, who reports to the CEO. Most hospitals today have a senior level portfolio that has responsibility for information management as a whole, including:

- Information Services
- Health Records
- Utilization Management
- Patient Registration
- Admitting
- Communications/Switchboard
- Library Services.

At some point, all information services should be reporting into one portfolio.

- The Chief of Staff's reporting relationship to the Board puts the Hospital at some risk. A Board should have only one 'employee', and this dual reporting relationship to the Board can only work when very positive reporting relationships exists between the Chief of Staff and the CEO. This is the case at QCH. Nevertheless, it presents a constant compromise challenge to the Board. The role of Chief of Staff is to oversee medical administration matters and clinical care management. The potential also exists for this role to assume responsibility for diagnostic service departments, but is largely dependent on the time commitment and associated compensation that can be arranged for the person in this role.

- The planning function lacks leadership. The fact that no one 'owns' the planning function in this time of dramatic change for QCH is a significant concern. While planning of the magnitude currently under way must be owned by all of senior management, someone who is specifically responsible for operational planning and who works in a highly interactive way with the senior management team is needed. The problems experienced with the transfer of the maternal/newborn program are a reflection of inadequate detailed functional planning. Although a 'bricks and mortar' planner is on contract, that role is quite separate from the role of a planner to oversee the operational planning process of a major capital project. Given the critical importance of the planning function in the next few years, this responsibility requires a specific assignment, possibly in a contract position for a two-year (or longer) period. For this period, the function should be directly responsible to the CEO. After that time, the function can be a part of the portfolio of the Vice President Finance. At the same time, a contract person cannot own the planning process on behalf of the senior management team. Much greater attention to this function is urgently needed.

- The Vice President Finance role is currently vacant and is being investigated as a potential integrated position with the Network 7a hospitals. A Vice President, Human Resources has just been recruited to head up human resource management for all Network hospitals. The HR function will therefore be removed from this portfolio. Depending on the outcome of that process, the Vice President Finance could assume responsibility for hotel services.

- The Director of Public Relations position is a staff position in support of the CEO and should be reflected as such rather than being on a similar level to vice president line roles.

The purpose of this review is not to make conclusions on specific changes to the organization structure of the Hospital. However, some of the issues addressed above will be important features of an

organization that is positioned to deal with a very tough expansion program and financial recovery process.

Planning Processes

The planning process for hospitals typically has four stages:

- Directional planning• where a future vision is confirmed (typically a three to five year horizon).
- Strategic planning• where the strategies required to carry the organization to the future are identified.
- Operational planning• where tactical initiatives are specified for each year. These plans are usually developed as a part of the annual operational and capital budgeting process.
- Master planning• where a facilities plan that will accommodate future directions is developed.

These planning stages typically occur at the organizational level first, with similar processes occurring within each major department so that these functional (or program) areas can effectively deliver their services in the context of the organization's overall plan.

Corporate Planning

Deficiencies in effective planning processes have contributed to many of the organization's current operational challenges. The Board did undertake a strategic program review in the spring of this year. This process, however, had three major flaws:

- The publication of C+ hospital programs by the Ministry became the focus of the review and encouraged a status quo solution, and in fact concluded some increases in services that are not considered to have sufficient on-call coverage. The fact that the hospital does not have the capacity for these increases was not addressed.
- The review was not conducted in the context of the fiscal situation at the Hospital. Although the need for constraint may have been discussed, the medical staff played a large role in driving this process and they were reluctant to delete any programs. Rather, they were willing to cut back the access of individual physicians• basically sharing the pain of cutbacks• rather than cut programs or services. Although this may be an effective strategy for this group of physicians or for a short period of time, it is not likely to be a permanent solution to the pressures being experienced at QCH.
- We are concerned that the thinking about a C (or C+) hospital role as a part of joint planning with WOVN is deflecting the attention of the senior management team from the urgent issues facing QCH.

Key to more successful corporate planning is the need for the senior management team to be taking greater responsibility for, and be actively involved in, the planning process, as we have previously discussed. The organization has recently initiated improved planning and decision support processes. These enhancements to the planning process are urgently required.

Departmental Planning

The lack of a comprehensive strategic plan for the organization is also influencing the planning process for individual departments:

- A high-level IT strategic plan was developed for QCH in 1999, but was then re-scoped to expand the process to include WOVN planning. High priority needs for QCH, which is significantly behind in its IT development process, were delayed in favour of WOVN plans. This has compromised some urgent information requirements at QCH.

- Many new initiatives are decided on an ad hoc basis, with little consultation, comprehensive impact analysis, and consideration of a broader picture. New physicians continue to be recruited to QCH without adequate impact analyses being completed. Even when an impact analysis is prepared for a 'vacant position', it needs to be updated with specifics related to a specific candidate when one has been identified.

- Operating room problems could have been avoided with better impact analysis, improved wait list management and better scheduling processes.

- Facilities planning is focused on 'bricks and mortar', not operations. Detailed planning was not done for the transfer of the maternal/newborn program, and we are concerned that a similar lack of attention to detail will create even greater problems with the next expansion phase. We understand that a planner is being recruited to take on this responsibility.

Operational Planning and Budgeting

The historical budgeting process was essentially managed out of the Finance Department. When funding was not an issue and activity was stable, this was an acceptable process. In recent years, the budgeting process has been more inclusive, asking for input from department managers with respect to workload and supplies. However, limited feedback is received on information submitted to senior management. Department managers learn of budget changes from variance reports once the budget is implemented.

The 2000/01 budget was not available until July 2000 due to major implementation problems with the new financial system. A new budget variance reporting system was introduced in September 2000. These were the first reports of performance for this fiscal year received by managers. This year's difficulties in reporting, coupled with the significant deficit that has been accumulating, have severely compromised managers and any ability they might have to do anything about fiscal performance.

Using a position control system to properly track requirements for additional staff and to better manage budgets could enhance the budgeting process.

Communications and Reporting Relationships

The smooth operation of any organization depends heavily on effective, frequent communications up and down the organization. Although general communications about hospital decisions are provided in an effective manner, the critical communications between department managers and senior management are weak.

Specific concerns about the communications between senior management and department managers include:

- The delivery of conflicting messages about what the physicians want and what boundaries exist within which the organization must operate. The sense of pressure created by physician demands that are conceded to leads managers to believe that the senior team is not making any tough decisions.

- The sense that senior management team is operating 'separately' from department managers, not engaging them in discussions about their areas and only involving them after decisions have been made.

The more stable environment of past executive teams provided a sense of confidence that QCH was an efficient hospital, capable of making difficult decisions. Coincident with the replacement of the former team and the arrival of the new team, the Hospital has also faced some of the most serious and difficult challenges of its 24-year history.

At a time like this, clear communications are required and department managers need to have confidence that the senior management team has the challenges of the organization in hand. The development of more positive relationships between these two management groups should be a high priority of the recovery planning process. We note that this process has already begun with departmental managers as an organization renewal process is initiated.

Conclusions

The senior management team has a number of critical management issues to address in order to move forward successfully.

- A successful planning process is critical to QCH at this time:

- The CEO must confirm the responsibility of all senior management in the planning process and ensure that leadership of the operational responsibility for QCH planning is assured.
- The CEO needs to ensure that appropriate attention to detail is given to all phases of planning to support expansion programs and new departmental initiatives.

- The parallel planning for WOVN needs to be integrated with the planning under way and modified in terms of scope and timelines until an approved role for QCH is confirmed.

- Operational planning and budgeting processes should be active regardless of external review processes.

- The CEO needs to immediately address the reporting relationship tensions in the organization between senior management and department managers.

- The organization renewal process that is being planned needs to be organized around priorities for change in the management and leadership process that will be a fundamental requirement of any team building efforts in the organization.

MEDICAL STAFF ORGANIZATION

The medical staff organization reflects a traditional organization structure and has all appropriate committees in place. Chiefs are appointed for each service. The Chief of Staff chairs the Medical Advisory Committee (MAC). Appropriate committee structures are in place.

The medical staff at QCH has enjoyed a number of years of 'steady state', where funding was not an issue and growth was relatively stable. Things such as the block assignment arrangement in the operating room, which attempts to be fair to all surgeons, evidence this. This type of working relationship among physicians is unique, and has enabled the organization to maintain a relatively positive relationship with the medical staff.

The physician resource planning process requires redevelopment. For example, recent planning for Obstetrics and Gynecology has resulted in a plan for a specific number of physicians that is being driven by practice preferences and an estimate of the number of deliveries that will be done by each obstetrician. Further, although the addition of new physicians in the past two years has demonstrated resource constraints, the appointment of new physicians with conditions such as 'no new OR time' or 'no changes in volume from the physician being replaced' can only last as a temporary measure.

Impact analyses are completed for all new physicians and programs or procedures. In some cases, the impact analysis is done for a new position when a candidate has not been identified, but is not consistently updated in detail once a specific physician is being recruited. These analyses lack the rigour required to fully understand the implications of a new physician's practice on the organization. Further, evaluations of the impact of new physicians in order to compare what was planned vs. what

actually occurred are not consistently done. A perfect opportunity exists to address this with the one-year review of the transfer of the maternal/newborn and gynecology services from the Grace.

The medical staff has successfully influenced the Board on clinical matters, even at the expense of fiscal control. The influence that the medical staff has had must change with new fiscal realities. More rigorous medical administrative processes are required as a part of recovery planning. Rather than having a physician-driven planning process, QCH needs to develop a needs-based planning process. This will avoid the key problem that is driving much of today's pressure at QCH, which is that too many physicians are on staff for the resources and physical capacity available.

Conclusions

The medical staff will face significant changes in process in the coming year.

- The CEO and Chief of Staff need to establish a physician resource planning process that is driven by community needs and available resources and is accompanied by thorough, candidate-specific impact analyses that are fully costed and fully completed before the Board reviews them for approval.

- Department managers impacted by any new physician or program need to have active and formal input into the physician resource planning process.

- The Board needs to undertake some sessions with the medical staff to increase their understanding of, and support for, the changes that QCH must undergo to achieve a balanced budget.

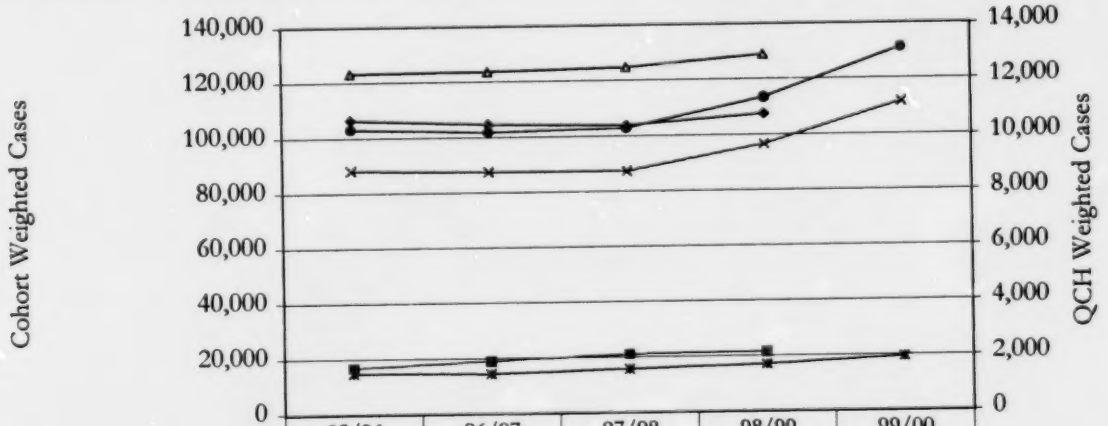
Clinical Performance

The review of clinical performance was limited primarily to operational issues, largely because of discussion about cost per weighted case already presented in the financial review. This chapter presents the results of the data review on clinical performance.

TRENDS IN ACTIVITY

QCH has seen steady growth in services over the past five years. Exhibit 14 presents the trend in weighted case volumes for QCH and cohort hospitals.

Exhibit 14
QCH and Cohort Hospital Trends in Weighted Case Volumes from 1995/96 to 1999/00



	95/96	96/97	97/98	98/99	99/00
Cohort Acute	106,504	104,678	103,790	107,525	
Cohort Day Surgery	16,816	19,009	21,056	21,444	
Cohort Total	123,320	123,687	124,846	128,969	
QCH Acute	8,818	8,746	8,721	9,656	11,180
QCH Day Surgery	1,491	1,443	1,568	1,697	1,944
QCH Total	10,309	10,188	10,289	11,353	13,124

* data for cohort hospitals for 1999/00 is not available.

The most dramatic change in service volumes has been seen in the past year. The introduction of the maternal/newborn program has caused a dramatic jump in cases in the past year for both acute inpatient weighted cases and day surgery cases.

CLINICAL UTILIZATION

QCH has responded to its challenge to maximize bed utilization in the hospital as a result of the pressures presented in the Emergency Department.

MNRH Cases

Cases that might not require hospitalization (MNRH) have declined at QCH as they have at other hospitals across the province. QCH, however, has been slow to act on this initiative. Exhibit 15 shows that MNRH cases are declining, as are associated MNRH days of stay. It also shows that QCH has only responded to this challenge in recent time.

Exhibit 15
MNRH Cases and Days as Percentage of All Cases at QCH and Cohort Hospitals

	1995/96	1996/97	1997/98	1998/99	1999/00
QCH CASES	11.8%	9.8%	10.7%	9.3%	6.3%
Cohort Cases	9.1%	7.3%	7.2%	6.1%	N/A
QCH Days	5.3%	5.1%	6.4%	6.0%	3.2%
Cohort Days	4.9%	4.0%	4.0%	3.6%	

* 1999/00 not available for cohort hospitals

Cohort hospitals were performing at levels below QCH through 1998/99. QCH has seen a dramatic drop in cases and days that will likely be at or close to benchmark performance in 1999/00.

Length of Stay

Exhibit 16 presents the average length of stay for QCH and the cohort hospitals for the past five years. The length of stay has been adjusted for case mix, complexity and age, and includes typical cases only (i.e. excludes outlier cases such as ALC patients).

Exhibit 16
Trends in Length of Stay for QCH and Cohort Hospitals

	95/96	96/97	97/98	98/99	99/00
QCH Average LOS	5.96	6.38	6.38	6.17	4.91
Cohort Average LOS	5.62	6.00	5.66	5.44	6.01
Difference in Days Per Case	0.34	0.38	0.72	0.73	(1.10)

QCH had an average length of stay that was higher than the cohort average until this past year. Aggressive efforts have been applied using InterQual data and other bed management processes to reduce the length of stay for specific acute cases as the number of ALC patients has grown. The breakdown of length of stay by level of care is presented in Exhibit 17. The length of stay has been adjusted for case mix, complexity and age.

Exhibit 17
Length of Stay by Level of Care for QCH and Cohort Hospitals for 1998/99 and 1999/00 (Typical Cases Only)

	1998/99	1999/00	Change from 98/99 to 99/00
QCH Primary Case LOS	4.52	3.06	(1.46)
Cohort Primary LOS	4.05	4.20	0.15
Difference in Days	0.47	(1.14)	
QCH Secondary LOS	7.85	6.61	(1.24)
Cohort Secondary LOS	6.85	8.07	1.22
Difference in Days	1.00	(1.46)	
QCH Tertiary Case LOS	7.91	9.00	1.09
Cohort Tertiary Case LOS	6.97	7.65	0.68
Difference in Days	0.94	1.35	

QCH has clearly put significant effort into reducing the average length of stay for primary and secondary cases, and has been more aggressive with these cases than the cohort hospitals. At the same time, the length of stay has increased by more than one day for tertiary cases. This is mostly related to joint replacements (knee and hip) and psychiatry. The Utilization Management team at QCH is currently addressing specific programs to deal with the length of stay for tertiary cases. A number of challenges exist with this group, because the availability of rehabilitation beds for patients recovering from joint replacement therapy is limited.

Overall, no opportunities for reducing conservable days have been identified. We encourage the current efforts of the Utilization Management Team to continue.

UTILIZATION MANAGEMENT

The utilization management process is well developed at QCH. In a 1998 utilization management survey by the Ministry of Health and the Ontario Hospital Association, QCH scored 230 points out of a possible 250 points on utilization management processes. The Hospital was the top performer in OHA Region 2 and among the top 10 in all regions.

The Hospital has invested significant resources in the use of InterQual as a means to concurrently review the process of care. The InterQual tool was first piloted in 1997. The tool was then used in a large trial in 1998 that included the use of a case management model and in 1999 InterQual was implemented throughout the hospital. The Clinical Utilization Team uses InterQual as one of a number of methods, including CareMaps and case management, to monitor and manage utilization most effectively. The Committee has made a number of recommendations that are directly focused at improved utilization, including and Urgent Referral Policy, an intervention process when the most responsible physician assignment is not clear, and care management processes directed at reducing readmission rates.

The use of InterQual has produced significant benefits for QCH. The active monitoring of admissions, particularly emergency admissions, has ensured that every patient being admitted requires hospitalization. As well, the active and real-time monitoring of cases has improved the coordination of care and enhanced the facilitation of discharge from the time of admission.

The achievements of the utilization management process are considerable and are reflected in improved length of stay performance. Those achievements include:

- Admission appropriateness for medical patients has improved from 84% in 1998 to 94% at the present time.
- Appropriateness of subsequent days of stay has improved form 67% in 1998 to 74% in 1999.

Overall, the utilization management process is working very well in the Hospital, and efforts are continuing to improve effectiveness and efficiency of care management this year.

Conclusions

The clinical utilization processes at QCH are steadily improving. In the future:

- QCH should continue its aggressive application of clinical utilization management processes.
- QCH should focus on improving the performance of specific tertiary care cases in terms of length of stay.

Departmental Operations

We discussed the past efficiencies of departmental operations at Queensway-Carleton Hospital in an earlier section of this report, as well as the confidence we have that as one-time costs are managed out of the system, the organization will return to an actual cost per weighted case that is lower than the expected cost per weighted case within the next two years. Because many planning-related issues that have already been discussed have become the focus of this review, we put much less emphasis on the review of departmental operations. In particular:

- We learned of many data quality and reporting issues that make any judgment of the organization's efficiency based on the data suspect.

- Department managers demonstrated many instances where they are focusing on their own review of efficiencies as a result of their own benchmarking experiences. Overall, we were very impressed with the quality and competence of department managers.

In this chapter, we review the results of the trending analysis and comparisons with benchmark organizations for selected departments.

Overall Change in Expenses

Exhibit 18 shows the change in net expenses for major department areas between 1996/97 and 1999/00.

Exhibit 18
Change in Net Expenses Between 1996/97 and 1999/00 for QCH

Description	Net Expenses 95/96	Net Expenses 96/97	Net Expenses 97/98	Net Expenses 98/99	Net Expenses 99/00	Variance from 98/99	% Change from 98/99
Nursing IP Services	11,253,676	10,556,642	10,765,937	11,916,916	15,249,724	3,332,808	28.0%
Ambulatory Care	5,206,039	5,191,244	5,411,608	5,749,966	6,372,334	622,368	10.8%
Inpatient Surgery	3,833,786	3,345,941	3,280,581	3,697,102	5,147,167	1,450,065	39.2%
Nursing Admin	534,939	454,532	369,700	463,428	768,134	304,706	65.8%
Diagnostic and Therapeutic	9,808,765	9,308,088	9,969,436	10,837,109	11,818,596	981,487	9.1%
Food Services	1,559,571	1,701,757	1,686,111	1,633,452	1,923,106	289,654	17.7%
TOTAL DIRECT COSTS	32,196,776	30,558,204	31,483,373	34,297,973	41,279,061	6,981,088	20.4%
Education	179,542	181,296	182,074	209,787	179,951	-29,836	-14.2%
Admin and Support	11,566,302	10,005,423	10,457,558	11,048,157	11,879,693	831,536	7.5%
Selected Expense/Rev Dist	1,285,380	2,065,939	1,605,230	1,722,807	871,101	-851,706	-49.4%
Undistributed Accounting Centres	-90,892	-67,508	-787,633	-827,624	1,137,637	1,965,261	237.5%
Total Adjustments	-1,186,111	-18,092	-69,747	-18,390	2,353,927	2,372,317	12900.0%
NET TOTAL OVERHEAD COSTS	12,940,332	12,185,150	11,457,229	12,153,127	14,068,382	1,915,255	15.8%
NET COSTS	45,137,108	42,743,354	42,940,602	46,451,100	55,347,446	8,896,346	19.2%
NET COSTS with adjustments	43,950,997	42,725,262	42,870,855	46,432,710	57,701,370	11,268,660	24.3%
NET Direct COSTS (adjusted)	31,350,710	30,545,270	31,432,236	34,284,394	43,034,660	8,750,266	25.5%
NET Overhead COSTS (adjusted)	12,600,287	12,179,992	11,438,620	12,148,316	14,666,710	2,518,395	20.7%

As can be seen, the overall expenditures remained quite stable until last year. We discussed the reason for this change in previous sections on this report.

NURSING SERVICES

Nursing areas have seen some of the greatest increases in expenses. Most of these increases can be attributed to the introduction of the maternal/newborn program. Exhibit 19 presents the changes in expenses for each major nursing area.

Exhibit 19
Trends in Inpatient Nursing Expenses at QCH

	Net Expenses 1995/96	Net Expenses 1996/97	Net Expenses 1997/98	Net Expenses 1998/99	Net Expenses 1999/00	Change from 1998/99
Medical	$ 3,715,046	$ 4,147,995	$ 4,347,523	$ 6,591,926	$ 7,408,418	12.39%
Surgical	$ 3,767,850	$ 2,491,395	$ 2,573,737	$ 3,034,452	$ 3,463,007	14.12%
Intensive Care	$ 1,168,253	$ 1,039,330	$ 1,059,139	$ 1,185,273	$ 1,362,992	14.99%
Psychiatry	$ 1,046,098	$ 1,105,458	$ 1,015,421	$ 1,105,265	$ 1,226,650	10.98%
Total IP Nursing	$ 9,697,247	$ 8,784,178	$ 8,995,820	$ 11,916,916	$ 13,461,067	12.96%

* Excludes Obstetrics

The increases in nursing expenses in last two years reflect the impact of the closure of chronic care beds and the increased focus on acute care during this period (including additional beds opened), resulting in a higher cost of service profile in 1998/99 and the inclusion obstetrics clinic costs in 1999/00. An additional reason for the increase between 1998/99 and 1999/00 is that salary increases for these two years were all accrued in 1999/00, thereby reflecting a higher cost than the cohort hospitals, which were benchmarked for 1998/99. This represents a 3-4% higher cost in QCH that should be disregarded in terms of efficiency

Medical Surgical Nursing Inpatient Benchmark Comparisons

Exhibit 20 presents the comparison of nursing inpatient expenses for medical and surgical inpatient units with the cohort hospitals.

It should be noted here that this table and all other comparisons to cohort hospitals, except Emergency, are based on 1999/00 costs for QCH and 1998/99 costs for cohort hospitals. This comparison was agreed to by the Data Committee but results in a cost at QCH, before activity changes, that will be 3-10% higher than the cohorts.

Exhibit 20

Benchmark Comparisons of Medical Surgical Inpatient Nursing at QCH for 1999/00 Compared to Cohort Hospitals for 1998/99

Facility Name	Cost per Patient Day	Cost per Workload Unit	Workload Unit per Patient Day
[redacted]	[redacted]	[redacted]	[redacted]
Guelph General	$ 179.10	$ 51.35	3.49
Kitchener St Mary's	$ 176.93	$ 44.84	2.99
Joseph Brant Mem.	$ 162.75	$ 46.29	3.63
Greater Niagara Gen	$ 170.09	$ 51.69	3.76
Orillia Soldiers' Mem	$ 179.58	$ 42.42	3.88
Ottawa Montfort	$ 156.95	$ 47.45	3.31
Scarb. Salvation Army Grace Gen	$ 173.55	$ 51.69	3.36
St Catharines Gen	$ 145.00	$ 42.42	3.42
Markham Stouffville	$ 188.70	Poor Reporting	Poor Reporting
Mean	$ 170.29	$ 43.24	3.48
25th Percentile	$ 162.75	$ 44.84	3.34
50th Percentile	$ 173.55	$ 46.29	3.45
75th Percentile	$ 179.10	$ 51.35	3.66
[redacted]	Above 75th Percentile	Above 75th Percentile	Above 75th Percentile

This comparison is affected by inflation and other cost increases at QCH in 1999/00. Year-to-year cost comparisons would place QCH at a much lower cost, but still within the 75th percentile performance. Workload units have not been used in this analysis because of the significant inconsistencies in reporting different workload measurement systems. Features of the higher costs in Medical and Surgical nursing units include:

- The case mix index for QCH is significantly higher than in cohort hospitals. This is further confirmed with the number of workload units per patient day compared to the cohort.
- The patient mix includes a high proportion of elderly patients. These patients, when acutely ill or in recovery phase of their illness, tend to require more hours of care associated with activities of daily living.
- The top-of-the scale pay rates for the very senior staff.

Overall, the staffing levels on the medical and surgical units are appropriate for the patient census and care requirements. The higher costs in these units are consistent with the patient profile of these programs.

Exhibit 20

Benchmark Comparisons of Medical Surgical Inpatient Nursing at QCH for 1999/00 Compared to Cohort Hospitals for 1998/99

Facility Name	Cost per Patient Day	Cost per Workload Unit	Workload Unit per Patient Day
Queensway Carleton	**$ 205.84**	**$ 53.91**	**3.82**
Guelph General	$ 179.10	$ 51.35	3.49
Kitchener St Mary's	$ 176.93	$ 44.84	2.99
Joseph Brant Mem.	$ 162.75	$ 46.29	3.63
Greater Niagara Gen	$ 170.09	$ 51.69	3.76
Orillia Soldiers' Mem	$ 179.58	$ 42.42	3.88
Ottawa Montfort	$ 156.95	$ 47.45	3.31
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Overall, the staffing levels on the medical and surgical units are appropriate for the patient census and care requirements. The higher costs in these units are consistent with the patient profile of these programs.

Obstetrics Inpatient Nursing Benchmark Comparisons

The benchmark comparisons for Obstetrics are not relevant because the unit was only in operation from December to March in 1999/00. The program transferred from the Grace in December 1999 and significant start-up issues were experienced. The staffing levels for this unit are appropriate now that the initial ramp-up phase is over, and the performance of this unit should compare favourably by next year.

Intensive Care Inpatient Nursing Benchmark Comparisons

Exhibit 21 presents the comparisons for intensive care nursing.

Exhibit 21
Benchmark Comparisons of Intensive Care Inpatient Nursing at QCH fro 1999/00 Compared to Cohort Hospitals for 1998/99

Facility Name	Cost per Patient Day	Cost per Workload Unit	Workload Unit per Patient Day
Queensway Carleton	**$ 704.09**	**$ 63.56**	**11.08**
Guelph General	$ 449.09	$ 61.93	7.25
Kitchener St Mary's	$ 740.62	$ 63.70	11.63
Joseph Brant Mem.	$ 627.79	$ 59.46	10.56
Greater Niagara Gen	$ 716.45	$ 51.41	13.94
Orillia Soldiers' Mem	$ 608.87	$ 46.51	13.09
Ottawa Montfort	$ 552.14	$ 58.48	9.44
Scarb. Salvation Army Grace Gen	$ 708.16	$ 57.46	12.32
St Catharines Gen	$ 539.88	$ 61.75	8.74
Markham Stouffville	$ 822.73	Poor Reporting	Poor Reporting
Mean	$ 640.64	$ 51.28	10.87
25th Percentile	$ 552.14	$ 51.41	9.27
50th Percentile	$ 627.79	$ 58.48	11.09
75th Percentile	$ 716.45	$ 61.75	12.52
	Between 50th & 75th Percentile	**Above 75th Percentile**	**Below 50th Percentile**

All intensive care units in hospitals in this cohort are difficult to staff efficiently because of the unit size and the high variability of patient types and census from year to year. The staffing in these units is essentially fixed because of the unit size, and will therefore be directly affected by the types and numbers of patients seen. In addition, QCH has a four-bed Constant Care Unit in Surgery, which allows the ICU to shift lower intensity cases out of ICU. Three key factors are influencing the costs at QCH:

Obstetrics Inpatient Nursing Benchmark Comparisons

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- The additional costs resulting from salary accrual and inflation. Removal of these additional costs would bring the unit closer to the 50th percentile.

- This unit also monitors the eight telemetry beds on the medical unit.

- ICU responds to codes throughout the hospital.

The staffing levels are appropriate and should be monitored carefully as plans for a new unit are developed, including the types of patients expected in the new unit and the associated nursing care requirements of those patients. The use of this nursing staff to cover areas outside of the ICU also needs to be closely evaluated based on the expected patient population in the unit.

Operating Room and Recovery Room

Exhibit 22 presents the costs in operating and recovery room expenses over the past four years. This area was not benchmarked because day surgery costs have not been separated from inpatient OR/PARR costs. Comparisons with cohorts are therefore not relevant. We have therefore looked at the costing trends for this area.

Exhibit 22
Trends in Operating and Recovery Room Expenses (including Day Surgery)

OR Activity	1996/97	1997/98	1998/99	1999/00	4 Year Change
SDS Cases	3,207	3,054	3,438	3,616	12.8%
Inpatient Cases	1,451	1,559	1,812	1,730	19.2%
Total Elective Cases	4,658	4,613	5,250	5,346	14.8%
Emergency Cases	1,021	1,057	964	1,246	22.0%
TOTAL OR CASES	5,679	5,670	6,214	6,592	16.1%
Endoscopy Cases	2,549	2,576	2,806	2,750	7.9%
Local Cystoscopy Cases	332	368	446	307	-7.5%
Total Costs	$ 3,345,941	$ 3,280,581	$ 3,697,102	$ 5,147,167	53.8%

Source: Operating Room Statistics; 1995/96 data unavailable

Costs for this area remained fairly stable for the first three years of this review period, showing the first substantial increase in 1998/99. Factors affecting costs in the last two years include:

- In 1998/99, a procedure room was converted to a day surgery suite as a result of the introduction of gynecology services transferred from the Grace.

- Day surgical cases were reported as ambulatory clinic visits in 1998/99, which was rectified in 1999/00.

- Obstetrical sterilization cases were added to the surgery service complement of QCH in 1999/00.

- The number of surgical day care weighted cases has increased substantially in the past year, largely as a result of the gynecology case transfer from the Grace.

- The increase in ER related cases has put additional pressure on the OR and has resulted in a rise in overtime hours to meet the demand for emergency surgical cases.

We undertook a more detailed review of this area because of the pressures being felt to manage the case volumes and beds efficiently. A summary of our review is as follows:

Departmental Performance

- QCH currently operates four full surgical suites. A converted endoscopy suite operates as a day surgical suite three days a week. There are plans to expand capacity to five full surgical suites as part of the new expansion. This will bring OR capacity to a net gain of two full days per week of surgical time by 2003. (The interim day surgery suite will revert back to an endoscopy suite when the expansion is completed.)

- Blocks are allocated on a "one person, one block" basis. Once the day cases are completed and urgent cases reallocated, all but one of the surgical suites are closed, with a single OR operating for evening ER cases. Physicians are unable to access surgical time once the dedicated OR is prepped for the evening shift.

- No automated surgical scheduling system is in place. All reports are compiled and analyzed manually by the Nurse Manager and the Utilization Management office. As a result, utilization is predicted based on the bookings and case mix rather than actual cases. As well, cases are booked based on block time rather than on the expected procedure time

- Reviews of operating room utilization are conducted by the OR Committee once every six months and are based on the predicted utilization history of each service. This is the only regular adjustment made to block allocation. Currently, the OR Committee is investigating the feasibility of allocating blocks based on service.

- Scheduling of surgical time has recently been extended to a three-week lead-time and is controlled by the OR Nurse Manager. A prioritization schedule has been implemented recently to handle excess capacity to reduce waiting times and to minimize the impact of cancellations.

- Waiting lists are managed by each surgeon and are shared with the nurse manager on a regular basis.

Issues

- The number of beds being used in the Day Surgery area for ER overload has a negative impact on the Operating Room. With increased utilization of both inpatient and ER volume, the ability to meet the demand for elective cases is diminishing. As a result, the reduction of available surgical beds due to medical case occupancy has resulted in an increase in non-medical related cancellations.

- The addition of two new urologists at the end of this year will result in the reduction of the urgent block time. While one urologist is expected to retire in the next few years, current medical manpower plans indicate that the organization will be looking to maintain three urologists on an ongoing basis. Unless capacity is augmented to meet the additional volume associated with these additions, the flexibility of the OR to accommodate urgent cases will be further reduced.

- The addition of the maternal/newborn program has increased the cost profile of the OR due to the increase in volumes. However, another consequence has been a reduction in ER surgical case flexibility due to the split in anesthesia coverage during evenings for deliveries. This has resulted in some delays in surgical cases waiting for the on-call anesthesiologist.

- The addition of gynecologists from the Grace has been accommodated through a process of 'sharing time'. New obstetricians and gynecologists are being recruited at the present time and the impact analyses are being presented as a 'net zero' impact on the operating room. This is unlikely to continue for any period of time. Within one year, the pressures of additional gynecologists and urologists are likely to bring the operating room situation to the point of crisis.

- The recent financial situation of the organization has resulted in considerable delays in the acquisition of new capital equipment, including information systems and surgical equipment. Only broken equipment is currently being replaced and a number of items are on trial from suppliers. Until an adequate funding base is established for the replacement and enhancement of new equipment and systems, the ability of QCH to meet the goals of the new expansion will be severely limited.

The current issues facing the OR are severe enough, including bed availability, OR time and the increasing volume of emergency cases as a result of increased Emergency Room activity. The expansion plans to add another OR, which in effect will add only two days to the capacity of the OR. At best, the additional OR time will accommodate existing pressures and some of the growth anticipated as a result of population growth.

Emergency Services

Exhibit 23 presents the benchmark comparisons of Emergency costs with cohort hospitals. We have used 1998/99 visit volumes and costs to calculate the cost per visit for this comparison. The comparison to 1999/00 data distorted the picture for this unit because of significant increases in costs in this year

due to pay rate adjustments and inflation. As we have previously noted, the comparisons of emergency services with the cohort hospitals are difficult to make because of the extreme differences in visit volumes compared to inpatient beds in these hospitals.

Exhibit 23
Benchmark Comparisons of Emergency Costs at QCH

Facility Name	# of Beds	# Visits 1998/99	Cost per Visit
Queensway-Carleton	201	52,866	$ 64.00
Guelph General	101	44,057	$ 67.05
Kitchener, St. Mary's	148	38,608	$ 77.45
Joseph Brant	228	39,723	$ 81.66
Greater Niagara Gen	214	61,600	$ 44.42
Orillia Soldiers' Mem	174	47,896	$ 51.76
Ottawa Montfort	195	28,385	$ 76.96
Scarb. Salvation Army Grace Gen	227	35,279	$ 71.79
St. Catharines Gen	223	45,519	$ 75.22
Markham Stouffville	172	33,575	$ 74.66
		Mean	$ 69.00
		25th Percentile	$ 67.05
		50th Percentile	$ 74.66
		75th Percentile	$ 76.96
			[redacted]

We undertook a more detailed examination of the Emergency Department because of the stress that the organization is experiencing in this unit.

Departmental Performance

Annual ER visits continue to rise. In 1999/00, visits were over 55,000. Of these, 16% involve patients 14 years or younger. An average of three per cent of patients (between 83-216 patients per month) were "overload" cases, meaning that these patients require hospitalization but no beds are available. As a result, these patients were accommodated in either the observation unit or the day surgery area. Patient volumes are indicated in Exhibit 24.

Exhibit 24
QCH Emergency Room Volumes from 1996/97 to 2000/01 (projected)

ER Volumes	Year					4 Year Change
	1996/97	1997/98	1998/99	1999/00	2000/01*	
ER Visits	50,730	50,836	52,866	55,623	60,391	19%
ER Admissions	4,132	4,277	4,574	4,961	5,170	25%
% of ER patients admitted**	8.15%	8.41%	8.65%	8.92%	8.56%	
Ave. Monthly ER Admissions	344	356	381	413	430	
% ER Admissions of total admissions to hospital	69%	69%	68%	71%	N/A	

* Projected
** Approximately 16% of QCH ER patients are 14 years or younger. Paediatric patients requiring admission are transferred to Children's Hospital of Eastern Ontario (CHEO). If paediatric cases are excluded, QCH's ER admission rate is 11-12%.

The department struggles with volume overload and is increasingly on Redirect Consideration (RDC) and Critical Care Bypass (CCB). Exhibit 25 presents the performance of QCH on RDC and CCB activity. The increased frequency of RDC and CCB from 1998/99 onward is consistent with increases reported in all Ottawa area hospitals.

Exhibit 25
Frequency of RDC & CCB Status of QCH ER*

QCH RDC/CCB	1998/99	1999/00	2000/01 (Projected)	Two Year Change %
RDC	2242 hours	3417 hours	4145 hours	46%
CCB	96 hours	134 hours	184 hours	48%

* CritiCall Resource Registry

Facilities

- The ER Department was built to accommodate ~30,000 cases.
- The physical capacity is inadequate and the current observation unit is "inhumane" —this unit was designed for six bays but currently supports 12.
- The space constraints result in issues re: patient confidentiality, privacy, inadequate access to equipment and hand washing facilities, as well as a lack of appropriate isolation and examining space.
- The department just recently requested 12 new stretchers to replace old, worn out stretchers that were contributing to staff injuries.

- A new ER is to be built as per HSRC directives, with annual target patient volumes of 63,000 visits.

QCH has attempted to respond to the growth and associated challenges in the Emergency Department.

- Staffing now includes 5 physicians (2 on days, 2 on Evenings, 1 on Nights) and the majority of the physicians have specialized preparation in Emergency Medicine.

- The nursing staffing levels have been increased over the last number of years to respond to increasing demands. The nursing staff has filed six workload related grievances to date this year.

- Management reporting has improved, but a significant proportion of this information is collected manually:

    - The department is tracking a number of relevant indicators.
    - A formal triage function was implemented in January 1999.
    - All patients are registered in the Cerner Patient Registration module and these data support demographic analysis of the patient population.
    - Since January 1998, coding of patient abstracts have been completed on patients admitted through ER using the MED2020 tool.
    - Coding of all ER patients began in April 2000. The Hospital experienced a number of system/data integrity issues during April – June 2000. These issues have been resolved and the quality of data from July forward has improved.
    - The InterQual tool indicates that 91% of patients (1999) are meeting admission criteria.

- The hospital has made minimal investments in information systems, specifically clinical information systems as a result:

    - Minimal automated "Results Reporting" capability is available, although a pilot was implemented in ICU and there are plans to expand access to this capability.
    - Minimal availability and use of information systems by clinical staff results in more time consuming, error prone manual methods.
    - The Chief of ER has had a longstanding interest in acquiring an automated ER patient tracking system. However, due to budget constraints no plans have been made to acquire such as system.

- Performance metrics:

    - ER is tracking patient volumes by age group, shift, patient waiting times, patient mix, LOS, and the required triage categories—much of this data is based on manual data collection.

- Monitoring utilization data has been identified as an area for continued focus. An automated ER tracking system would support this requirement
- The "Door to Needle time" (i.e. the time from patient arrival in ER to the time of administration of thrombolytics) of less than 30 minutes for patients presenting with acute chest pain/MI is considered excellent by Canadian standards. The target is less than 60 minutes.
- The percentage of patients who left without being seen is less than 1% --remarkable given the LOS and physical environment
- Currently the department is not able to track re-visits to ER with defined time periods (e.g. within one week, within one month) due to system limitations but the hospital is exploring ways to track this data.

- Work Flow/Patient Flow:

  - Work flow/patient flow is impacted by the limitations of the physical space and layout. Space is extremely cramped, e.g. the unit was designed for ~30,000 visits and the observation unit was designed for six stretchers.
  - The department consists of physically distinct areas, line of sight is restricted and this impacts coverage
  - The ER is interested in exploring ways to provide more timely service to non-urgent cases e.g. a "fast track" but it is currently hampered by the lack of space, and overflow patients staying in the ER due to a lack of inpatient beds.
  - The ER is seriously impacted by the lack of inpatient beds. Twenty four percent of patients who have been admitted routinely stay in the ER/Overflow area for 12-24 hours. These admitted patients overflow to the Day Surgery area and are impacting elective surgery. Industry experience indicates that the length of stay in ER is related to the length of stay in hospital, i.e. once the length of stay in ER reaches 24 hours the inpatient length of stay also tends to increase.
  - The use of the Day Surgery area has provided relief for the ER, is in keeping with MOHLTC directives regarding measures to avoid RDC/CCB and demonstrates the cooperative environment of the medical staff. However, this situation has become unsustainable.
  - Space/bed constraints are causing gridlock on a frequent basis and time on RDC and CCB is increasing. Adding more staff will not address this problem.
  - The department has added a discharge resource to the ER. However, opportunities to strengthen the linkage with the CCAC need to be explored. No formal "Quick Response" effort is in place, although a trial was done five to seven years ago. Efforts have been reported by both CCAC and QCH to improve this process, but the relationships between these two organizations needs to be enhanced.
  - The ER works closely with Patient Registration and the patient care unit managers to manage beds. However, all bed management data is managed manually due to information system limitations.
  - Bottlenecks identified in work processing include inpatient bed availability, physical space and unit layout, and coverage of orphan patients due to an Internal Medicine back log

- Access to specialists at other centres is also an issue. Currently, access varies by service. For "regional" services, e.g. neuro, paediatrics, trauma, there are well-established patterns and access and referral processes work well. For services that both QCH and the other centres offer, (and for which QCH historically had its own coverage e.g. Urology, GI,) the department reports significant difficulty obtaining access to relevant specialists or acceptance of referrals
- Some physicians continue to see patients in the ER (e.g. "meet me in ER"). Although the number of these types of occurrences has declined, and the hospital has begun active management of this practice, the acute space and volume constraints require that this practice be eliminated.

- This department is clearly struggling under very difficult conditions. The expansion into a new facility will alleviate some of the patient care quality and work life quality issues that are an obvious strain on everyone. The current staffing levels are appropriate for the workload as is evidenced by statistics such as average waiting times and the low number of patients who leave without being seen. However, the new ER will require greater numbers of staff given the size and layout. For the period between now and the opening of the new ER, temporary measures to make the situation in the Emergency Department better for patients and staff alike should be implemented. This can likely be done without incurring any significant additional resource costs. For example:

    - A trailer could be used to re-direct non-urgent visits. This area should have minimal staffing (similar to a walk-in medical centre) and the Hospital should be prepared to risk the complaints that come from this. A notice could be given to all patients explaining the expected wait times, the reasons, etc. The use of volunteers as greeters may help.
    - The QCH team should immediately sit down with the case managers from CCAC to re-consider some form of Quick Response team.
    - Urgent action should be taken to manage the overload patients so that they are not moved to the Day Surgery area, thereby causing surgery cancellations.

Direct Care Administration

Direct care administration costs have shown a dramatic increase in the past year. Benchmark comparisons were not done for these costs because of significant reporting differences between hospitals. The changes in costs for this area at QCH for the past five years are summarized in Exhibit 26.

Exhibit 26
Trends in Direct Care Administration Costs at QCH from 1995/96 to 1999/00

Year	Net Expenses	Percentage Change
1995/96	$534,939	
1996/97	$454,532	(15.0%)
1997/98	$369,700	(18.7%)
1998/99	$463,428	25.3%
1999/00	$768,134	65.8%

This change in expenses shows the decrease in expenses in the earlier years of the analysis based on the cost containment initiatives that were undertaken at the Hospital. Last year, the significant jump in costs are specifically related to:

- The transfer of the maternal/newborn program for the Grace.
- An augmentation in support to nursing units in clinical nurse specialists/nurse educators, which had been removed in previous years. In 1999/00 1 FTE staff educator was added to support ER and Surgery and 1 FTE Clinical Nurse Specialist was added to Medicine and ICU.
- The costs of the staffing office are also reported here for 1999/00.

We reviewed the nursing administration positions and found the organization to be appropriate for a hospital of this size.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Diagnostic and therapeutic services expenditure trends are presented trends in Exhibit 27.

Exhibit 27
Trends in Diagnostic and Therapeutic Expenses for Acute and SDS Activity at QCH from 1995/96 to 1999/00

Description	Net Expenses 95/96	Net Expenses 96/97	Net Expenses 97/98	Net Expenses 98/99	Net Expenses 99/00	% Change from 98/99
Total Lab	$ 3,079,097	$ 2,716,664	$ 2,681,815	$ 2,770,745	$ 2,593,814	-6.4%
Total Diagnostic Imaging	$ 2,954,209	$ 2,783,955	$ 3,113,553	$ 3,587,167	$ 4,315,150	20.3%
Total Therapies	$ 3,775,459	$ 3,807,469	$ 4,174,068	$ 4,479,197	$ 4,303,803	-3.9%
Total Diganostic and Therapeutic	$ 9,808,765	$ 9,308,088	$ 9,969,436	$ 10,837,109	$ 11,212,767	3.5%

The sub-department cost trends in laboratory and diagnostic imaging services are misleading due to significant data reporting differences from year to year. We have therefore focused our review on the overall cost trends in these areas.

Overall, the costs in diagnostic and therapeutic areas have increased a very slight 3.5% in the past year. This is due in part to the significant increase in ambulatory care activity. For example, 51% of the procedures performed in diagnostic imaging come from the Emergency Department, so the growth in that area will not be reflected here.

Specific cost increases and decreases can be explained due to changes in practice:

- Laboratory costs have declined due to Almonte opting out of participating in the shared regional laboratory service, as well as the consolidation of pathology technical processing and of hematology staffing into biochemistry.

- The increase in costs in diagnostic imaging in 1999/00 (20.3%) can be attributed to the introduction of the CT scan and Nuclear Medicine programs.

- The increases in therapy departments can be attributed to the significant increase in patients requiring additional support (elderly acute care patients, ALC patients).

Overall, none of the diagnostic and therapeutic departments revealed any substantial variances that are of concern.

ADMINISTRATION AND SUPPORT DEPARTMENTS

None of the administration and overhead departments have shown significant increases in 1999/00 that cannot be explained. Some general comments about these areas include:

- Food Service costs are higher than benchmark hospitals because of the food distribution system in place. QCH is a part of the Hospital Shared Service Corporation, of which Hospital Food Services is a division. Meals are individually assembled (based on menu selection), delivered, thermalized, and picked up through Food Services, resulting in higher distribution costs as compared with the cohorts. As well, capital maintenance is somewhat higher at QCH as a result of aging equipment.

- Materials management costs are higher due to the Friesen-concept design of QCH. The hospital is not a complete Friesen facility but conducts its operations in the spirit of the design. Purchasing, printing (forms), mail distribution, and management costs normally allocated to other areas of the organization reside in materials management as a result of the Friesen approach. As well, the addition of the maternal/newborn program, and the addition of the CT Scan required further staff increases for portering and related services.

- Health records and registration costs are higher than the benchmark hospitals. The key factors for the higher costs:
    - Registration staff are responsible for scheduling and booking functions for Ambulatory Care, Diagnostic Imaging & Cardiopulmonary and the OR
    - Registration staff also support ER patient registration functions and admission of ER patients
    - Registration staff covers the switchboard for night shift.
    - Health Records includes a higher number of Health Records Administrators (HRA) versus Health Records Technicians (HRT) and clerks than other centres. The staffing mix and distribution of work are currently being reviewed and changes are being implemented to improve resource utilization and productivity.
    - Health Records is staffed 24 hours per day.
    - The hospital has a centralized chart that results in a significant amount of handling and processing to ensure completion and to support record check in/check out procedures.
    - The current information systems provide minimal support for efficient operations. The Patient Registration/ADT system is old and has weak functionality in terms of ability to provide timely access to census and bed management information. The lack of integration between Health Records/Central Patient Index and ADT has resulted in issues with data integrity. The department also reports a high number of duplicate patient records. The amount of online storage for patient encounters is limited and has recently been reduced. This has compounded issues related to duplicate records.
    - Health Records does not have the benefit of a chart-tracking module.

INFORMATION SERVICES

Information Technology has not been a priority of QCH over the last number of years and the hospital has a relatively low level of automated systems in place. IT operating expenditures as a percentage of budget are low, ranging from 0.68% to 1.95% for 1996/97 to 1999/00 (typically this is in the 2%-3% range).

External resources have been used for major components of its information systems/systems support. For example, until 1999, the financial applications at the Ottawa General Hospital (OGH) were used, and the IT function was completely outsourced to DINMAR in 1997.

QCH completed a draft IT strategic plan in July 1999. Subsequently, an IT plan was completed for WOVN, replacing the plan for QCH. While a regional perspective is helpful for IT strategic planning and this initiative is consistent with all other joint corporate function initiatives with WOVN, steps to address the priority needs of QCH, including a functional ADT/CPI system, appear to have been delayed as a result of the WOVN planning effort.

Currently, patient management functions are supported with legacy Cerner Classic applications. Many limitations exist given the age and generation of these applications. Reporting capabilities are limited and report requests and timely turnaround of report requests is an issue.

The level of integration between the Cerner applications is low. The systems communicate via batch interfaces, and as a result, real-time information is limited.

A new financial system from ORMED was recently installed as an alternative to the OGH financial systems support that was discontinued. The ORMED installation followed an extremely accelerated, ambitious implementation schedule in order to meet the Y2K deadline. The Finance Department is still in the process of stabilizing operations and developing optimized work processes based on the new system.

This past summer, QCH also participated in the preparation of several Canadian Health Infrastructure Partnership Program (CHIPP) grant proposals.

CONCLUSIONS

Departmental operations have generally been found to be efficient, although opportunities do exist to improve performance:

- The operating room has continued to operate on a one person/one block system that is seen to be fair to all surgeons. A review of block times by service compared to waiting times by service should be done to ensure that the current system is fair to patients as well as surgeons.

- Alternatives to the management of non-urgent visits to the Emergency Room should be sought, including use of a separate temporary space outside of the Emergency area. Primary health care reform initiatives may also help.

- A Quick Response program alternative should be discussed with the CCAC representatives. The fact that this has not been revisited in five or more years demands that it be reconsidered. In this process, QCH and CCAC representatives should explore ways to improve and strengthen their cooperative efforts and initiatives so that every possible avenue for supporting the QCH Emergency Department and inpatient bed challenges are identified.

- Physicians on call in the Emergency Room who are using the Emergency Room as a place to see patients should be stopped.

- The current review of the staff mix and 24-hour staffing in Health Records should result in some savings in this area.

- An aggressive review of information systems requirements and priorities should be undertaken, including priorities for QCH that have been delayed as a result of WOVN planning and the outsourced management of this department.

Although significant savings cannot be expected from the review of departments noted above• and in some cases increased costs can be expected• attention to these efforts should be incorporated into the recovery plan.

A Recovery Plan Process for QCH

This chapter outlines a series of recommendations for QCH and the Ministry to follow to develop a balance budget strategy for the organization. It provides a starting point for more detailed discussions that will direct activities and provide performance measures for the next several months.

THE CASE FOR CHANGE

The Board and executive team, as well as the Ministry, must accept the realities of the current situation at QCH as the basic premise for required change:

- The unprecedented growth of the last several years cannot continue without major adjustments to the role, capacity and funding of QCH.
- The growth of 8% per year over the past four years and a projected 12% this year cannot be sustained. Even if funding and role issues are resolved, the organization must manage growth more aggressively.
- An accountability framework is needed that clearly specifies the roles and responsibilities of the Board and senior management in managing resources within funding provided, and which clearly articulates the rationale to all stakeholders.
- QCH must then have an operational plan that is accepted by all stakeholders, that is implemented, and for which the organization is held accountable.

This level of accountability has not been in place. The process must begin with a full discussion with the Ministry on the current and future situation of QCH.

BOARD DEVELOPMENT

The Board, through its Operational Review Steering Committee representatives, must be committed to a recovery that includes a change in governance and management styles that will prevent a similar fiscal situation occurring in the future. The perception that the growth and associated costs are not containable must be changed to an attitude of fiscal control, and each funding year must be approached with the acceptance that the organization must live within the envelope of funds provided. The Board must direct the CEO to take whatever actions are necessary to do so. Based on this review, we conclude that the Board of QCH needs assistance with this process, and that once a development process is completed, the members of this Board will be better equipped to move forward with a financially healthy organization.

In order to evolve to a culture of responsibility that will ensure a stable financial future for the organization, the Board requires education and support to strengthen its governance role, including:

- The overall role of the Board. This Board can act responsibly if it remains at a distance rather than becoming more involved in the organization. A review of the role and responsibilities of Board members is required, including its relationship with medical staff and the expectations

that it should have of its chosen representative, the CEO. The Board must then embrace all organizational values, which should include the delivery of a balanced budget.

- The planning responsibility of the Board. The Board must take a strong leadership role in planning. The primary planning function of the Board is to identify a long-range plan for the organization, obtain agreement from the Ministry on that plan, and then monitor the operationalization of the plan.

- The monitoring responsibility of the Board. The Board should expect and get management reports that outline what is being done to fulfill the mission and mandate of the organization, including explanations of any variations from the strategic and operational plan and what actions are being taken to re-align priorities with these plans. In particular, the Board should receive full-disclosure financial reports that clearly outline the current and future position of the hospital.

RECOMMENDATIONS

We recommend that:

(1) The Ministry appoints an individual to provide advice and support to the Board for a period of six to nine months, and who is accountable to the Ministry.
(2) The Board Chair and the Regional Director of the Ministry of Health and Long-Term Care meet to establish 'ground rules' for communication about capital, fiscal and governance matters.
(3) The Board and the Ministry immediately establish an agreement regarding working capital for the remainder of this fiscal year.
(4) The Board and the Ministry immediately agree on an appropriate level of activity for the hospital that can be used to establish base funding.
(5) The Board and the Ministry confirm the base funding adjustment required over current base funding.
(6) The Board Chair directs the CEO to develop comprehensive and compelling operating plans to support the use of fiscal resources in each fiscal year.

MANAGEMENT DEVELOPMENT

The senior management team is in transition and needs to establish a cohesive management style and process as a top priority. The recent departures of two of the three vice presidents and the short tenure of the CEO (27 months) and the third vice president (one year) have complicated the management of some very complex issues in the past two years. Although senior managers have been very aware of the growth in costs, they have been unable to, or uncertain about how to, manage this growth within available resources. The management team needs to:

- Understand and demonstrate a sense of urgency to identify and deal with current and future growth crises.
- Build a sense of team in the leadership of the organization.
- Confirm the short-term vision for QCH and develop a longer-term vision as soon as possible, and communicate that vision throughout the organization.
- Ensure that all priorities of the organization lead to the vision.
- Organize people and processes most efficiently.
- Work with the medical staff to align their priorities with the organization's vision.
- Communicate effectively to all stakeholders within and outside of the organization.
- Find creative solutions by removing barriers to manage growth more effectively.
- Enhance and maintain effective management processes, and specifically improve processes such as:
  - Planning and budgeting
  - Decision-making
  - Communications
  - Management reporting and accountability.
- Develop and maintain effective relations with the Ministry.
- Keep the Board informed of progress.

As the recovery planning process begins, the CEO must keep the organization focused on the recovery of the organization. The individual appointed by the Ministry to help the Board can have a key role in providing advice and counsel to the CEO. This person should act as a catalyst between the Ministry and the executive team so that Ministry decisions are forthcoming in a reasonable timeframe.

The terms of reference for the individual should be specific, and a clear accountability to the Ministry should be stated regarding the progress made toward expected outcomes. Further, the individual needs to work with the CEO to establish specific performance objectives over the next six to nine months and then to guide and support the CEO through the recovery process.

RECOMMENDATIONS

We recommend that:

(7) The individual appointed by the Ministry provides oversight guidance, advice and support to the CEO and the senior management team, and is responsible to the Ministry for reporting the achievement of stated outcomes.

(8) The CEO completes the recruiting process for the vacant senior management positions.

(9) The CEO confirms the corporate responsibility for planning related to capital development and WOVN.

(10) The CEO continues initiatives already in progress to build positive and proactive relationships between department managers and the senior management team.

(11) The CEO ensures that the organization renewal process is organized around priorities for change in the management and leadership process and is focused on the strategic outcomes of the recovery plan recommendations.

MEDICAL STAFF ISSUES

The full involvement of the medical staff will be critical to the success of the recovery and ongoing stability of QCH. The growth in demand, although primarily coming through the Emergency Department, can be managed only with the active support of the medical staff. The strategic program review conducted last spring needs to be re-visited in light of a new role and mission for QCH, and the physician leaders must fully embrace any new directions or mandates required to manage growth more effectively. This can only happen if the medical staff are involved and committed to the process.

RECOMMENDATIONS

We recommend that:

(12) The Board Chair, CEO and Chief of Staff ensure that the medical staff play key role in, and are involved with, the recovery process.

(13) The Board Chair and CEO ensure that medical human resources plans are consistent with the role of QCH, are accompanied by detailed impact analyses, and are affordable within the financial resources available.

DEPARTMENTAL OPERATIONS

Overall, QCH departments are operating very efficiently. Some opportunities exists to improve effectiveness and to prevent future operational problems.

RECOMMENDATIONS

We recommend that:

(14) The Vice President, Patient Care services seeks alternatives to the management of visits to the Emergency Room, including a revisit of the Quick Response Team initiative and alternatives to handle non-urgent walk-in cases.

(15) The Vice President, Patient Care Services considers a study of the block booking system currently in place in the operating Room.

(16) The CEO undertakes an aggressive review of information systems requirements and priorities.

FISCAL RECOVERY

As we have noted throughout this report, the financial problems at QCH are not related to efficiency, which will be demonstrated in an actual cost per weighted case that will be below the expected cost per weighted case by the end of the year. Rather, the primary causes are due to growth, inflation and one-time costs.

Exhibit 28 (on the next page) presents the recent financial performance of QCH. Revenue assumptions are based on 2000/01 funding included in the base for 2001/02 and funding for the 20 beds annualized to $3,200,000. All other revenues are assumed to have 1% growth. Expenditure assumptions include a projected 5% growth and 5% inflation calculation added to the March 31, 2001 projection.

Based on current growth trends, the expected deficit by the end of this fiscal year will be approximately $7 million. Without any adjustments in funding, the projected deficit next year will be in the range of $12 million.

Through this review process, agreement has been reached that the role of QCH needs to be re-visited. The funding base therefore needs to be adjusted.

RECOMMENDATIONS

We recommend that:

(17) The Ministry and the Board negotiate appropriate funding level for an agreed level of activity at the hospital.

(18) The CEO and management team continue efforts to manage transition costs out of the system.

A New Role for QCH

This review has confirmed that the role for QCH in the future will have to be adjusted to meet the growing demands of its immediate catchment area and to allow the organization to serve and support the needs of Ottawa-Carleton and Network 7a. This will mean significant change for the organization.

RECOMMENDATION

We recommend that:

(19) The Ministry of Health and Long-Term Care and the Board of the Queensway-Carleton Hospital confirm a new role for QCH:
- Based on HSRC recommendations to 2003
- Based on growth to 2008.

Exhibit 28

QCH Year-end Projections for 2000/01 Compared to Budget and 20001/02 Projection

	Nov-00 Year to date Actual	2000/01 Year end Projection	2001/02 Projection	2000/01 Annual Budget
Revenue				
Approved M.O.H. Allocation	$30,991,769	$48,247,157	$50,247,157	$44,518,533
In-patient	394,311	591,467	597,381	450,000
Out-patient	3,063,826	4,595,739	4,641,696	5,476,080
Diff.pref. accom.	2,403,959	3,605,939	3,641,998	3,923,200
ALC co-pymt	145,210	217,815	200,000	130,000
Amort. of Capital Grant				
- equipment	637,704	956,556	966,122	956,552
- building	379,584	569,376	575,070	569,375
Ambulance	118,298	177,447	179,221	125,000
Laboratory Revenue	928,946	1,393,419	1,407,353	1,568,561
Parking Revenue	678,376	1,017,564	1,027,740	1,050,000
Other Revenue	1,148,300	1,722,450	1,739,675	1,266,149
Other votes	100,261	141,388	141,388	141,388
	$40,990,544	$63,236,316	$65,364,801	$60,174,838
Expenses				
Non-medical salaries	27,903,373	42,531,108	46,890,547	42,531,108
Medical staff remun.	2,094,772	3,425,612	3,776,737	3,425,612
Employee benefits	3,465,290	5,494,781	6,057,996	5,494,781
Med. & surg. supplies	2,147,539	3,204,146	3,532,571	3,204,146
Drugs	838,267	1,257,401	1,386,284	1,151,398
Other supplies & exp.	6,471,425	10,504,453	11,581,159	10,804,453
Bad Debts etc.	133,336	200,004	220,504	200,000
Interest-commissary	628,705	904,583	997,303	904,583
Deprec. - shareable	1,374,134	2,061,201	2,272,474	2,037,802
- Other	817,787	1,226,681	1,352,415	698,269
Other votes	100,261	141,388	141,388	141,388
	45,974,889	70,951,357	78,209,378	70,593,540
Net loss year to date	$(4,984,345)	$(7,715,041)	$ (12,844,577)	$ (10,418,702)
Add: Deprec. - other	817,787	1,226,681	1,352,415	698,269
Less: Amort of grants	379,584	569,376	575,070	569,375
MOH Format	$(4,546,142)	$(7,057,737)	$ (12,067,232)	$(10,289,808)

RECOVERY PLAN SCHEDULE

The changes needed at QCH are urgent. We encourage a recovery plan schedule that will ensure a timely recovery of the organization and the opportunity to have the fiscal and management performance of the organization back in line during the 20001/02 fiscal year.

RECOMMENDATIONS

We recommend that:

(20) The Ministry and the Board agree to a recovery plan schedule that reflects the urgent need for improved fiscal and management performance.

(21) The Board of QCH develops a policy that will guide the organization in the maintenance of a balanced budget.

Exhibit 29 presents a recommended schedule for recovery.

Exhibit 29
Proposed Recovery Plan Schedule

Activity	Target Deadline
Resolve working capital position	Feb. 28
Establish funding for current activity	Mar. 31
Plan for transition costs out	Jan. 31
Plan for unit costs back in line	Complete
Role for QCH:	
- For current redevelopment	Mar. 31
- For future	Sep. 30
Governance and management oversight	Sep. 30

This timetable is very aggressive for both parties. However, a strong commitment to change, and associated measurable actions, will be the cornerstone of a renewed organization.